South Gloucestershire Safeguarding Adults Board

Safeguarding Adults Review – Nightingale Homes

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Contents:

NB The details of all adults referred to in this Report have been anonymised by the lead reviewer.

1. Introduction

Nightingale Homes Ltd ran three Residential Care Homes in the South Gloucestershire Area. The Homes had been registered for many years, one of the people included in this Review was placed at a Nightingale Home in 1994. The Commission for Quality Care (CQC) had rated one of the Homes as "Good" in 2015, and the other two Homes as Good in some domains and Requires Improvement in others. During 2015 – 2016 concerning themes emerged about the running of the Homes and the wellbeing of the people who lived there. After CQC inspections in 2016 all three Homes were rated as overall "Inadequate" and, despite the efforts of a "turnaround" team the three Homes closed in 2017. The concerns which led to the closure of these services are briefly summarised in section 4.

In September 2017 South Gloucestershire Safeguarding Adults Board (SGSAB) decided to commission a multi-agency Learning Review, to capture learning from agency interactions with the care provider. The SAB was particularly interested in how failings in the Nightingale services were not recognised when there was so much professional interaction with residents at the three Care Homes.

Once the first draft of the Learning Review was received the South Gloucestershire SAR sub group, after taking legal advice, decided to continue with the Review as a statutory review, or SAR, as the Learning Review process had identified serious harm to at least one Adult at Risk and the criteria for a SAR had therefore been met, i.e. "*An adult with care and support needs (whether or not those needs are met by the local authority) in the SAB's area has not died, but the SAB knows or suspects the adult has experienced serious abuse or neglect and there is concern the partner agencies could have worked together more effectively to protect the individual*". Care Act 2014

2.Purpose of the Safeguarding Adults Review

South Gloucestershire Safeguarding Adults Board decided to commission a Review in which the responses of the agencies external to the Nightingale Homes would be the source of learning, not the incidents within the Homes themselves. The learning from the Review must be capable of being used by the SGSAB to develop steps to overcome the barriers or challenges in how agencies work together to address concerns about quality or harm in provided services.

The thoughts and experiences of the people who lived in the Nightingale Homes and their families were also considered as part of the learning. What was the experience of living in the

Homes, did the people and/or their families have concerns, and if they did who could they ask for help?

The timescale considered by the Review is from 1st January 2015 to 24th August 2016. South Gloucestershire Council (the "host authority") initiated organisational abuse procedures at the end of August 2016, and at this point ensured that all agencies had begun to be informed of the nature of concerns. The Review focuses on agencies who worked with all three of the Care Homes owned by Nightingale. Four research questions are explored:

- Were concerns noticed by practitioners within the scoping period?
- What were the barriers to sharing concerns about practice at Nightingale Care within the scoping period?
- How effectively are professionals working with adults who have care and support needs sharing information about care providers in South Gloucestershire?
- What further steps can be taken by the South Gloucestershire Safeguarding Adults Board to improve practice in this area?

3.Methodology

Fourteen agencies contributed individual reports to the Review Panel, focusing on their agencies involvement with the Care Homes and the perceptions and experiences of the staff visiting them. To facilitate this process a workshop was held for Report authors to familiarise them with the requirements of the Report and to support them to avoid the bias of hindsight, but to understand events from the perspective of practitioners working in the context of the time. Agency reports were received from:

Five local authorities, including the host local authority, South Gloucestershire.

The GP practice where all Nightingale Residents were registered

Avon and Wiltshire Mental Health Partnership

Sirona NHS and social care

BRISDOC Healthcare Service

South West Ambulance Service NHS Trust

Avon and Somerset Constabulary

A Training Provider

The Care Quality Commission

North Bristol NHS Trust

Individual reports received were analysed by the lead reviewer to identify key themes. These were presented at a learning Workshop with authors and representatives of the agencies involved to sense check the initial findings and to work together to identify learning.

Placing agencies were asked to approach the people who had lived in Nightingale Homes to ask if they wished to be involved in the Review, and if so at what level of involvement? If the person agreed or was unable to make a decision about participating in the Review, their family or other representative was approached. Levels of involvement were: 1. not at all, 2. being updated and reading the Report post publication, 3. giving their views to the author or reviewer on what it was like to live at a Nightingale Care home including suggestions as to how things could be improved, 4. potentially if wished meeting with a group of other people or families to share experiences and learning 5. and/or reviewing the learning from the Review and adding any learning that had been missed.

Six people who had lived at the Homes and eight family members contributed their experiences to the Review. Some of the people who lived at Nightingale did not wish to discuss their experiences, they wanted to move on with their lives, some were not able to understand the purpose of the Review and had no family or friends to represent them. One family member wished to meet up with others, but no other family members wished to do so. Ten participants would like to contribute to learning after the Review is completed.

The experience of all those living in the Nightingale Homes has been documented briefly below. All names are anonymised, a different name has been given to each person and as many of their identifying details as possible have been removed. One of the themes running through the Review is the invisibility of some of the people at Nightingale to many of the external agencies responsible for their care and support. The lead reviewer places them where possible at the heart of this Review.

4.Background

4.1 The period in scope, January 2015 to August 24th, 2016, was one of great change in health and social care. Significantly, the Care Act 2014 was implemented in April 2015. This was a reform of all legislation relating to adults in need of care and support and introduced new practices whilst reaffirming and clarifying the responsibilities of authorities funding care and support. Adult Safeguarding structures also changed with a new emphasis on enquiry for all eligible adults who are or may be at risk of harm and a personalised approach to involving people in their own safeguarding. Some local authorities, in this Review LA “A” in particular, restructured their services at around the same time.

In all local authorities Deprivation of Liberty Safeguards (DoLS) teams were overwhelmed with the increase in numbers of people who required an assessment post the Cheshire West decision of March 2014. Many people referred to DoLS teams were placed on waiting lists

which were prioritised using a tool provided by the Association of Directors of Social Services (ADASS). Details on how the context of change influenced practice is given in section 5 below.

4.2 The three Nightingale Care Homes were located within 2.5 miles of each other, Bedrock Lodge was in the Hambrook area of South Gloucester with Bedrock Mews and Bedrock Court in the same road ten minutes drive away from Bedrock Lodge. The Homes are as described by CQC in 2017 below:

- **Bedrock Court** provides accommodation and personal care for up to six people aged 18 years and over.
- **Bedrock Lodge** provides accommodation and personal care for up to eleven people aged 18 years and over.
- **Bedrock Mews** provides accommodation and personal care for up to six people aged 18 years and over.

The Homes were all identified as providing care and support for people with learning difficulties and mental health needs.

4.3 Concerns identified by CQC in each of the Homes can be found in published reports on the CQC website: https://www.cqc.org.uk/

These published concerns can be usefully summarised by using the six thematic headings devised by the University of Hull (Marsland et al 2012). The University of Hull's research found that indicators of organisational risk may be scattered across all domains, however from experience of using this research in practice the lead reviewer would argue that indicators in the first domain: concerns about "*management and leadership*", would be a strong indicator of risk in all domains, as was the case in the Nightingale Homes.

Summary of CQC identified concerns September 2016:

1. Management and Leadership

- *The provider/registered manager struggled with the management of the whole service and there was an inconsistency in approach*
- *There was a lack of insight and vision as to how they intended to improve the service. Systems for monitoring the quality of care were not robust enough and had failed to identify the serious failings of the service.*
- *The provider/registered manager had not taken advantage of opportunities to keep themselves up to date with best practice or develop partnerships with key organisations.*

2. Staff skills, knowledge and practice

- *Staff were unsure how to respond to challenging situations, they had no training in addressing individual needs, or plans/management support to address needs, staff*

were unsure how to help distressed or anxious people and had no skills to do so. They had no training in or use of specific communication skills, many of the people they cared for communicated without spoken words.

- *No understanding of using the provisions of the Mental Capacity Act 2005 or the significance of the Deprivation of Liberty Safeguards, key in this service where many people did not have the capacity to make decisions about their own care and support needs.*
- *Records and plans were described as value laden and judgemental.*
- *Staff were observed to congregate together and did not engage with people*

3. Quality of basic care and environment

- *Medication practices were unsafe*
- *Staff were implementing inappropriate physical interventions.*
- *Care was not person centred*
- *The premises were stark and cold, "not a homely place to be".*
- *"Every door with a lock is locked", including toilets, bathroom and kitchen.*
- *The external grounds were unsafe to walk in.*
- *CCTV cameras were in use without review*

4.The way services were planed and delivered

- *Risk Management plans were inadequate, care plans were not used, and showed little detail, often being inaccurate regarding the persons' needs.*
- *There were inadequate staffing levels at night, and insufficient staff during the day, apprentices were used to deliver care and support unsupervised.*
- *People had to follow "house rules" and fit into the service.*
- *In emergency staff had to contact the owner/manager before contacting emergency services, staff were unclear what to do in emergency or urgent situations. There was no on call system.*

5.Residents behaviour and well being

- *People had to ask to use the toilet and could not enter the kitchen to make snacks or drinks*
- *Some staff were reported and observed (by inspectors) to be disrespectful, aggressive, shouting and pushing people. Dignity was not observed.*

- *Care planning, the rigid routines within the service and staff approach to people, all contributed towards dependence being fostered. People had lost, or did not gain, independence*
- *People had little or no observation or support from staff. On several occasions people were observed to be startled or frightened by another person who was clearly agitated and anxious. There were no staff close by to reassure the person.*
- *People's money was not well managed by the owner/manager who acted as their appointee.*

6. Resisting external involvement

- *No external advice sought regarding people who had a range of specific needs. External advice was ignored when given.*
- *"Lifestyle" plans and behaviour management plans were in place for a number of people with little or no involvement from relevant health and social care professionals*
- *Health and social care professionals consistently spoke about the feeling they were 'kept at arms-length' from the service. In fact some felt, the provider/registered manager was resistant to any advice given and portrayed an attitude of 'knowing what was best for people'.*
- *The experience of people using the service was of a closed environment. They lived at the service, used the day care facilities at the service and activities and holidays took place mainly in groups. People were not encouraged to have contact with family or friends.*

5. The Agencies

In Section 5 the activities and responses of the external agencies involved in the care of people living at the Nightingale Homes are described and analysed. In the first part of this section the agencies with fundamental responsibilities toward each individual, the "placing authorities" are examined. In this account the experience of each individual, as far as is known to the lead reviewer, will also be described. In the second part of this section the activities and responses of the other agencies involved will be examined.

5.1 Five local authorities placed people in Nightingale Care Homes and were responsible for monitoring their wellbeing and reviewing their need for care and support. These are "placing authorities" as referred to in the ADASS (2010) protocols on ordinary residence (pre-April 2015) and in the statutory guidance which accompanies the Care Act 2014. One person living at Nightingale Homes was self-funding, i.e. their care was arranged and paid for by their family.

A "host authority" is the local authority in which other local authorities have found accommodation for an adult with care and support needs who they are continuing to fund.

Section 7.1 of the ADASS (2010) protocols required a placing authority to inform the host authority in writing of individuals they have placed in a "residential setting" within the host authority's boundaries, this was intended to be helpful when resolving adult safeguarding matters or if a host authority is faced with a Home Closure or other emergency. In practice, local authorities rarely inform each other of placements, and have developed no mechanisms to retain or use this information if indeed they did.

All local authorities have a duty to undertake regular reviews of the care and support needs of the people they place in residential care, wherever this may be. Prior to the Care Act legislation (Community Care Act 1990) stipulated that reviews must occur at least every 12 months.

Under the provisions of the Care Act 2014 a third party, for example a Provider, can undertake a review, but there is no suggestion that any of the local authorities took this step post April 2015. The Care Act stipulates that a Review should occur 6 – 8 weeks after a placement starts, and reviews should be planned at the appropriate time for the person, considering their needs and mental capacity, but no later than every 12 months. Unplanned reviews should take place:

"*If there is any information or evidence that suggests that circumstances have changed in a way that may affect the efficacy, appropriateness or content of the plan, then the local authority should immediately conduct a review to ascertain whether the plan requires revision. For example, this could be where a carer is no longer able to provide the same level of care, there is evidence of a deterioration of the person's physical or mental wellbeing or the local authority receives a safeguarding alert".* Chapter 13.15 Care Act Statutory Guidance 2014

Put simply, reviews are an essential component of the local authorities' responsibility to ensure that an Adult it has placed in a residential setting is enjoying all elements of "wellbeing" and that the service providing care is meeting their needs in the way that has been agreed, and if the Adult's needs have changed, for developing a plan with them to meet those needs in a different way or different setting. These responsibilities are particularly pertinent if the Adult lacks capacity to make their own decision about their care and accommodation and has been placed after the local authority has made a "Best Interest" decision on their behalf.

5.2 LA "A," was responsible for fifteen people in Nightingale Homes during the time in scope and as such had filled the majority of the placements available there (the total of potential placements in Nightingale Homes was twenty-three with twenty-six people included in the scope of this Review). Whilst this can be established in hindsight it appears that at the time, LA "A" could not easily identify who they were funding in each Home. The "Bedrock" Homes were registered individually and do not appear to have been identified as being under one owner or as part of "The Nightingale Group". It is understood that LA "A" has now developed a system to easily identify who it is placing and where. This could also assist in enabling the local authority to determine where it should be undertaking over arching "quality checks" on

providers who are caring for a number of adults it has placed. The majority of people placed at Nightingale were the reviewing responsibility of one adult care team, giving an opportunity for an understanding of the number who were the responsibility of the LA. This was a fairly new team however, created during LA "A" s reorganisation, team members and the team manager were new to this particular geographical area. It should also be noted that some of the people funded by LA "A" had come into the auspices of the local authority in 2012, after a previous re-organisation which saw people who had been reviewed by the Mental Health Trust now the responsibility of the local authority. Like other local authorities, LA "A" did not inform the host authority of the names of the people it had placed in its area.
The border of LA "A" is around two miles from the Nightingale Homes location, but there were few actual physical contacts between LA A and the people they were responsible for at Nightingale Homes.

Six people had either a review of their needs, and therefore a visit from LA "A" to the premises during the time in scope, or not a review, but a visit to the premises. All but two of the "reviews" that took place were only recorded on case notes, not in the required format, and do not appear to have been detailed assessments of the adult's wellbeing and care and support needs, they were not compliant with the legislative requirements of the local authority or indeed its own policies.

Mr Smith had been an inpatient in a mental health hospital for some months. He was assessed as not having the mental capacity to make decisions about his own care and accommodation. A best interest decision was made for him to be discharged from hospital to a residential care home in September 2015 and a placement was sought for him for three weeks before Nightingale Care assessed him as suitable to move to Bedrock Lodge. Mr Smith moved to Bedrock Lodge on the 13th October 2015. He was 24 years old at the time and the youngest person by sixteen years in Bedrock Lodge. No review was carried out to ascertain if the accommodation was meeting the needs of Mr Smith, who was not capacitated at this time to make those decisions himself. Nightingale Care did not make an application for a Deprivation of Liberty assessment, something which would have provided an overview of his care and protected his rights. Mr Smith was placed in a "Review Pool" by LA "A", it is believed that the "Review Pool" was a list for planned reviews, but LA "A" were not undertaking planned reviews at this time, they report that they did not have the staffing capacity to do so. Mr Smith was visited regularly by a Community Psychiatric Nurse (CPN) who, eight months after his placement, contacted LA "A" to ask for a review as he was concerned that Mr Smith's needs were not being met at Bedrock Lodge, the accommodation was unsuitable for him. Mr Smith was visited by two staff members from LA "A" but no review took place, no paperwork was completed, no Care Act Assessment carried out, Mr Smith's care and support needs were not considered. At the end of the period in scope Mr Smith was still living at Bedrock Lodge.

Mr Jones was also an in patient in a mental health hospital when Nightingale Care were contacted In February 2016 to ask if they would assess his suitability for their service. Some thought was given by both provider and placing authority as to whether Mr Jones would be compatible in terms of need and risk with the others who lived at Bedrock Mews. Mr Jones did have his care and support needs assessed whilst in hospital and was accepted by Nightingale Care on a "three-month trial", moving in March 2016. He was 33 years old. Three weeks later Mr Jones' placement was reviewed "*informally*", his social worker met with him and a member of Nightingale staff, recording that "*he is happy and appreciating the quieter lifestyle*". No formal review appears to have taken place of Mr Jones' support plan and there was no contact with the other professionals providing support to him. A week later an Approved Mental Health Professional, who was also acting as Mr Jones' nearest relative, contacted LA "A" concerned that Mr Jones was being kept in the Home against his will and with no legal framework to support this. A social worker contacted Nightingale Care who admitted they were "*struggling*", Mr Jones was withdrawing from caring for himself or engaging with activities. LA "A" did not visit Mr Jones or conduct a review. In May 2016 Mr Jones' CPN also contacted LA "A" saying that Mr Jones was unhappy, the placement was "*too restrictive*". The social worker did not visit, although the "*three-month trial*" had come to an end. The social worker rang Nightingale staff to hear how Mr Jones was doing and was told that things were going well. By July 2016 Mr Jones' CPN was clear with LA "A" that Mr Jones *"is locked in the house every day if he doesn't get up on time. ….. is missing transport to the day service, that he is left locked in the house - he has access to food, drink and the back garden but cannot leave the premises"*

LA "A" still made no visit to the Home but accepted the CPN's offer to try to sort out the restriction and Mr Jones' unhappiness. The CPN reported the matter to the mental health trust adult safeguarding lead, but LA "A" did not appear to recognise this matter as an adult safeguarding issue. By mid-August 2016, the end of the period in scope of this Review, the CPN offered to look for a new placement for Mr Jones "*his mental health is suffering as he is in an Learning Difficulties (LD) placement and he doesn't have an LD. He said things are getting worse not better and thinks the placement needs reviewing quite urgently. If he doesn't get up at 9.30 he is locked in the house all day as the staff take the other residents to day activities. CPN thinks this is a deprivation of liberty".*

Mr Jones placement had not been formally reviewed by LA "A", despite information that it was not only unsuitable for Mr Jones but that his rights were being removed by the provider. LA "A" made no contact with the host local authority, in particular the Adult Safeguarding team, to discuss concerns.

Mrs Rose was an inpatient in a mental health hospital and subject to the oversight of the Court of Protection. Mrs Roses' move to Bedrock Lodge in May 2016 appears to have been well planned and was reviewed formally and fully within a month of the placement beginning. Mrs Rose had an advocate; her social worker attended her Care Programme Approach

meetings, working carefully with other agencies to ensure her needs were met, and Nightingale staff engaged with LA "A" in facilitating contact with her family and in sending in paperwork which would be needed to report to the Court of Protection officers. Mrs Rose was 67 years old when her placement began.

Mrs Black was placed in Bedrock Court in 2013. A concern in January had prompted her mental health care team (AWP) to ask Nightingale to make a safeguarding referral to LA "A". AWP were not prepared to close Mrs Black's case until they had some confirmation about the outcomes of this referral, correctly referred to LA "A" as the alleged harm had occurred in their area. AWP continued to follow this up by email until a written response was reviewed from LA "A" to Nightingale, confirming that the referral was not thought to be a safeguarding matter. A Care Act compliant review was held with Mrs Black and Nightingale staff in August 2015, it was recorded that Mrs Black was *"happy living at Bedrock Court and attending Bedrock Lodge day centre".* Mrs Black was very distressed in December 2015 as she was increasingly anxious about the welfare of a family member. She had assaulted a member of staff and caused damage to the property. LA "A" does not appear to be aware of this concern, and indeed during December placed Mrs Black in the "review pool," assistance for Mrs Black appears to have come from the mental health team alone.

Mrs Black has told the lead reviewer that the best thing about living at Bedrock Court is that she could see her family member more frequently, and that the staff there enabled her to do so on a planned basis.

Mrs Wiltshire lived at Bedrock Lodge, she was placed there in 2012 and was almost 70 years old at the time of events, her care needs had become very complex. She did not have the capacity to make decisions about her care and accommodation during the time in scope. Mrs Wiltshire had diabetes and circulatory issues. Staff at Bedrock Lodge were finding Mrs Wiltshire's behaviour difficult to work with and in May 2015 asked her GP to refer her to a mental health team for assessment. The visiting CPN found her care plan "*covered everything I would suggest*" and prescribed Lorazepam to be taken when required (0.5mg). In November 2015 Nightingale staff asked the GP to refer again, as the PRN Lorazepam "*was not working*". Mrs Wiltshire was assessed in November 2015, her Lorazepam, now 1mg up to three times per day continued. She was very agitated and had hurt staff members who were trying to assist her with personal care. She is described by the mental health team as "*putting herself on the floor*". Mrs Wiltshire was referred by her GP to the mental health "Later Life "team for more mental health assessments and further guidance to Nightingale staff. She was seen by this team in December 2015, her anti-psychotic medication and Lorazepam was reduced as the dosages were high for an older person, and these drugs were thought to potentially have an impact on her mobility. The assessing psychiatrists noted that Mrs Wiltshire may have been too anxious to walk, and so arranged assessments from an AWP physiotherapist and occupational therapist. Over a period of three months and six visits various aids and adaptions were tried. In March 2016 the Nightingale staff were given

a plan by AWP staff to try to support Mrs Wiltshire which had positive advice on activities and strategies including

"*If (Mrs Wiltshire) puts herself to the floor, staff are leaving her (once they are happy that she is safe and there are no dangers such as something she could tip over or bang into) and returning in say 10min, as (she) is able to get herself up. This should be continued as the safest and most appropriate way of managing this*".

This plan required a consistent approach from all staff. The Later Life team reviewed the plan in May 2016 after Mrs Wiltshire was discharged from hospital following sepsis. Nightingale staff had found her "*unresponsive*" in her room after an afternoon nap on 4th May 2016 and called an ambulance. They also submitted a safeguarding referral to the host authority. At the same time a "*whistle blower*" reported concerns about Mrs Wiltshire's manual handling. LA "A" reviewed on 12th July 2016, case notes on the review are sparse, no formal review was carried out and no outcomes from this review are recorded, there was no change to Mrs Wiltshire's care and support plan. Mrs Wiltshire was complex in her presentation at this point, but the reviewer was a non-qualified worker who may well have struggled to understand the degree of complexity presented. No reference was made to AWP staff who would have had a great deal to contribute to a review as they had been previously been intensively involved with Mrs Wiltshire.

From the 22nd July her GP noted concerns about a red area on Mrs Wiltshire's hip which by 1st August 2016 was described as an ulcer and being managed by the local district nursing team. The GP noted "*Patient is diabetic, Staff report that she lays on the floor much of the time. Apyrexial and deep ulcer. To coordinate review with District nurse - this lady may need referral to secondary care early given her high risk and size of ulcer*"

Mrs Wiltshire had been referred to the LA "A" DoLS team in March 2015 and was visited by a Best Interests Assessor (BIA) on the 27 July 2016 whilst back at Bedrock. As part of his assessment the BIA noted that Mrs Wiltshire should be assessed for equipment and an OT assessment for moving and handling should be carried out. He thought that Mrs Wiltshire's behavioural issues were severe enough for CHC funding to be considered, the BIA was concerned about Mrs Wiltshire's care, and put conditions onto Nightingale Care to ensure that the GP followed up a request for a review by specialist mental health services as a high priority, and to discuss with the Mental Health team plans to manage some aspects of Mrs Wiltshire's behaviour. The BIA was concerned that Mrs Wiltshire was being given Lorazepam as a "chemical restraint", was concerned about her quality of life. Although 2:1 care was commissioned for her by LA "A" the BIA could not be sure that she was receiving this. The BIA did make an adult safeguarding referral to the host LA on 27th July 2016, concerned at the use of "*chemical restraint on three occasions*" without, on two occasions, any PRN medication record being signed. The host authority allocate this concern to a social worker for further enquiry, around this time an additional two other concerns were reported to the host LA regarding how the staff were treating Mrs Wiltshire, on 22 June an

anonymous report had been made to CQC regarding an historical aggressive verbal response made by a member of staff to Mrs Wiltshire, and on 5th August 2016 the assistant manager at Bedrock Lodge advised that a member of staff had again been very verbally aggressive to Mrs Wiltshire. The host LA social worker made a visit to Bedrock Lodge to speak with Mrs Wiltshire on 18th August and was concerned that there was no manual handling equipment to enable staff to support Mrs Wiltshire to get up from the floor. Mrs Wiltshire's ulcer had by this time deteriorated to the extent that the Home called the BrisDoc Out of Hours team on 5th August.

During the time in scope LA "A" did attend two strategy meetings regarding Mrs Wiltshire held by the host authority, undertook a DOLS assessment and a review of her care and support needs. The review was not properly recorded and had no clear outcomes. A number of agencies were attempting to support Nightingale staff in caring for Mrs Wiltshire but appear uncoordinated and unaware of each others activities. A multi agency review could have indicated a clear pathway of care, or the need for a new placement. Mrs Wiltshire's health deteriorated further post August 2016 despite regular visits from District Nurses and GP input. She was admitted to hospital on an emergency basis on 14th December 2016 and had to undergo emergency surgery for an abscess that had gone into her hip bone. She died on 21st March 2017, the cause of death being: 1. Osteomyelitis of the right femur; and 2. Schizophrenia.

Mr Price lived at Bedrock Mews. He did not have a review during the time in scope but did have three visits from his social worker to the premises, one in July and two in December 2015. The purpose of these visits was to plan Mr Price's move on to living with his family. The plans made appear detailed and the social worker undertook a good deal of planned communication with all parties to ensure that the move went well.

Nine people were not visited by LA "A" whilst at Nightingale Care during the time in scope.

Two adults, Mr Timms and Mrs Newton, had been the responsibility of the local mental health trust until all social care functions undertaken by the Trust passed back to the local authority in 2012. Neither had any visits or reviews of their care and support needs recorded by LA "A." Mr Timms was referred for a Deprivation of Liberty assessment in 17 March 2015 but placed on the waiting list. He had lived at Bedrock Court for ten years and was 68 years old. Described as generally in good health by his family, he had begun to experience falls and was becoming increasingly frail. Mr Timms brother noticed threadbare carpets and was concerned that his brother was climbing stairs. Mr Timms brother complained about the condition and treatment of people at Bedrock Court in August 2016. Mr Timms died in September 2017.

Ms Newton and her family have described how "controlled" life was for her at Nightingale and that whilst that may have helped her when first admitted from hospital, seven years later her ability to be independent and make her own decisions was stifled. A review of her care and support needs could have identified that Mrs Newton, now aged 55, would benefit from

a different type of support. It is reported that information about Mr Timms and Mrs Newton was lost in the transfer between mental health trust and local authority. A review or visit would have perhaps identified this absence of information about them.

Both Mr Timms and Ms Newton had families who visited them. Mr Brown and others funded by LA "A" at the Nightingale Homes had little outside representation. Mr Brown was 50 years old and lived at Bedrock Court. In January 2015 he had a seizure and was taken to the local hospital Emergency Department (ED) by Nightingale staff. He had swelling to his frontal lobe. He was referred to the DOLS service in March 2015 and went onto the waiting list. As he had no family an Independent Mental Capacity Act advocate was appointed to visit him to ascertain his circumstances. It is not known if this visit occurred. On 4th November 2015 Nightingale staff informed LA "A" that Mr Brown had been moved to Bedrock Mews as on 29th October he had become distressed and slipped from the toilet, breaking his nose. He was taken to the GP four days later who advised taking him to A and E, he was also referred to the dental hospital. Mr Brown's GP raised a safeguarding concern about this incident but there are no notes of this concern in the host authority report. Although Mr Brown had moved accommodation and was injured no visit or Review was made by LA "A" in response to this information. Mr Brown was admitted to the local acute trust hospital on Christmas Day 2015, with the symptoms of pneumonia, he was discharged from hospital care on 6th February 2016. NBT submitted a safeguarding referral to LA "A" regarding concerns about Mr Brown's care in hospital on 10th February but this was not sent onto the hospital social work team for further Enquiry by the LA decision making team until the 10th of March. The hospital social work team asked NBT to enquire into certain parts of the concern but did not record anything further regarding the outcome of the enquiry. Nightingale Care also reported their concerns to LA "A" regarding Mr Browns discharge from hospital, but this was not received until March 2016, having allegedly been sent in January 2016. Mr Brown's physical health began to decline in the early part of 2016, his diabetes now needed control with metformin, he had recurrent chest infections and experienced difficulty swallowing and moving his head. LA "A" did undertake a range of s42 Enquiry activities regarding Mr Brown's discharge from Hospital whilst the host local authority also undertook two Adult Safeguarding meetings following Mr Brown's death in May 2016. The host authority recorded that Mr Brown had been admitted to hospital on 2nd May, staff had noticed on 28th April that he had some facial "drooping". He was thought to have pneumonia again and discharged with antibiotics, he died the following day at Bedrock Mews. The host LA undertook a joint investigation with police to understand the circumstances around Mr Brown's death. LA "A" did not take part in this, they were sent minutes of a strategy meeting and awaited further contact.

Mr Short was 61 years old and lived at Bedrock Court. A referral to the DoLS team was made in March 2015 and he was placed on a waiting list. LA "A" did not review his care during this time and did not visit the Home. Mr Short was found to have died in his bed during the night on 23 November 2015. As this was an unexpected death police officers attended and

expressed concern over the procedures staff had followed after Mr Short's death, i.e. not summoning an ambulance. No harmful practice was substantiated by the host authority's subsequent safeguarding investigation which concluded in December 2015. Minutes were sent to LA "A". GP records show that diagnosis and treatment of Mr Short's health problems was difficult, because of his learning difficulties he could not understand instructions or the purpose of interventions, but was achieved by careful planning for investigations, i.e. ECG in January 2015. Mr Short had a cataract removed in February 2015 and just before his death was due to have all of his teeth extracted. He appears to have to be sedated with Diazepam and attended by two carers during his ECG test which he was objecting to, but the provider did not make the LA "A" DoLS team aware of the necessity of doing this, something which may have re prioritised Mr Short's position on the DoLS waiting list.

Mr Long lived at Bedrock Mews and was 50 years old at the time in scope. He had no visits, or Review of his care and support needs. He was on the Deprivation of Liberty Safeguards waiting list from 17 March 2015 onward. His outbursts of anger are mentioned by ex fellow residents and Nightingale staff consulted his GP with concerns about this aspect of his behaviour but did not ask LA "A" to review his needs.

Mr Blue lived at Bedrock Mews and was 53 years old at the time of events. He had not had a Review of his care and support needs since 2012 and had no review during the period in scope. Mr Blue was referred for an assessment under DoLS in March 2015 and placed on a waiting list. From April 2016 Mr Blue was being supported by Nightingale staff to accept investigations and treatment for cancer, diagnosed in July 2016. He underwent distressing tests and surgery. Mr Blue was also supported by his CPN who saw him regularly and who had originally identified concerns relating to his symptoms in April 2016. LA "A" have noted no communication from the provider or mental health trust regarding Mr Blue's situation.

Mr Grey was 60 years old at the time of events and lived at Bedrock Lodge. He had not had his care and support needs reviewed since 2012 and did not have a Review during the time in scope. He was referred to the DoLS Service in March 2015 and was placed on the waiting list. Apart from poor health related to his chest there is nothing recorded about Mr Grey. He now lives in Bristol but is reported to have not had the mental capacity to understand the purpose of the learning Review.

Mr Wooller lived at Bedrock Court, he was fifty-four years old. He was due for Review by LA "A" in June 2015 but was at that time detained in mental health unit some 40 miles away. At a CPA meeting on 15th August Mr Wooller's psychiatrist asked the social worker to make an approach to Nightingale but there is no evidence from the social worker's case notes that any contact was made.

Mr Wooller's social worker did visit him in September on the unit and initiated an assessment of his care and support needs. Mr Wooller was very unwell, his social worker did

not think it likely he could return to Bedrock and Nightingale staff were also saying that "*They want to have him back but concerned about the risks of how they would manage him if he is still unwell"*

Mr Wooller was discharged back to Bedrock by the mental health service at the end of September 2015. His social worker does not appear to have been consulted about the discharge plan. The social worker noted that Nightingale staff worked hard to represent Mr Wooller's needs and concerns with the mental health team.
Mr Wooller was re admitted to hospital, this time to a unit over 50 miles away, at the end of October 2015. He returned to a unit in Bristol a few weeks later but was not responding to treatment. Mental health staff continually expressed concern that Mr Wooller would not be suitable to return to Bedrock Court. His social worker was concerned that there were few other options available, "*Bedrock aren't trained to do restraint in the event of Mr Wooller becoming physically aggressive so clinical staff feel that he requires a higher level of support, perhaps even a mental health nursing service or a forensic service. I explained that it might be very difficult to secure these types of placements as there aren't many of them out there"*
The social worker worked with mental health staff to plan his discharge back to Bedrock, he returned in January 2016. The situation quickly broke down and he was re admitted to a mental health unit. LA "A" gave notice to Nightingale Homes, Mr Wooller could not return there. In August 2016 a different LA "A" worker approached Nightingale as Mr Wooller was about to be discharged from the unit, previous recording should have indicated that this placement was not able to meet his needs. Nightingale decided not to offer an assessment to Mr Wooller, saying that he had "*lost confidence*" in them and a future relationship with him would not be workable.

Miss Bird was admitted to Bedrock on 16th August 2016, toward the end of period in scope. Miss Bird had to move from her original placement as her behaviours were very challenging to staff. A new placement was sought for Miss Bird over a period of five months. The social worker who had placed Mrs Rose contacted Nightingale independently as he had though that this placement had progressed well. Nightingale assessed Miss Bird on 16th August and agreed they could admit her on the 28th August 2016.

In summary, themes emerging from exploration of LA "A" s contact with the people who lived at Nightingale Homes show a very limited number of face to face contacts, a lack of Care Act or Community Care Act Reviews consistent with either legislation or policy and a limited response when informed of potential changes in the nature of people's needs. The absence of multi agency reviews or of assessment of care and support needs, meant that for some opportunities for independence was lost, for others coordination of very complex needs was neglected, or the decision that the provider could no longer meet a person's needs was not made. Some of the most complex reviews were allocation to unqualified workers, or "social care practitioners". Families were not consulted as part of the review process, information received was not checked with them and there appeared to be no

relationship, apart from Mr Price, with the families or representatives of people at Nightingale.

The provider could have kept LA "A" better informed, but in the absence of a named worker may well have not been encouraged to do so.

The pressure to move people from badly needed mental health hospital beds is also referenced in LA "A"s account and this, coupled with the felt and real concerns that placements were hard to find for some people leaving hospital appears to have led to Nightingale's offers of placements being readily accepted without careful consideration of whether needs could be met or regular review of the wellbeing of the person.

Accounts from LA "A" explain that during this time no planned reviews were taking place and that in November 2013, there had been a reduction in staff numbers following a restructure within the teams and a move to more generic working. "*There were teams identified to complete reviews, but the bulk of their work involved unplanned reviews, so few planned reviews could take place. Due to demand pressures on the responsible teams, unplanned review requests were also having a delayed response time".*

5.3 LA "B" funded one person in the Nightingale Homes, Mr Snow. Mr Snow was 58 years old at the time of events and lived at Bedrock Court. He had been placed in Bedrock Court in 1994. LA "B" is located 85 miles from Bedrock Court. Mr Snow had lived there since 1994. He is described by LA "B" as having a set of complex needs, as result of a severe learning disability and autism. Mr Snow is non-verbal and his only means of communication is through limited use of Makaton signs, pointing to objects or leading people to where he wishes to go or to an object of reference. LA B has assessed that Mr Snow does not have the capacity to understand his care and support needs.

Mr Snow was referred for a DoLS assessment on 6th March 2015 and placed on a waiting list. LA "B" has a system to track and alert when a review of care and support needs is due. Mr Snow's annual review was due in August 2015. Records from the local acute trust show that Mr Snow was seen at the Emergency Department on 10th May for a laceration caused when he injured himself whilst distressed.

Nightingale Care telephoned LA "B" in June 2015 and gave a detailed report of Mr Snow's current physical health. LA "B" was informed by the provider on the 5th June 2015 that Mr Snow had put his elbow through a window.

The involvement of the local mental health and learning disabilities teams was noted, together with interventions that Mr Snow had required from primary and secondary health care. Mr Snow was described as still distressed and had demonstrated some unusual behaviour, lacerating his arm and requiring hospital treatment. This information was recorded well but not passed onto either the worker's manager or the specialist placement team responsible for reviewing Mr Snow.

Mr Snow's Review took place in October 2015. Despite the other agencies described as involved in his recent care, the Review did not involve any other agencies. The Review recording is described as "*containing information which had not been checked for accuracy and relevance*" which had been drawn through from other reviews. The review did not address Mr Snow's rights under the Mental Capacity Act, i.e. no Mental Capacity Act Assessment had been undertaken, therefore, no best interest decision had been made which resulted in no independent representation for Mr Snow during this review. In addition, the review did not include views from other professionals involved in the care and support of Mr Snow. The review carried forward actions from 2014 which the provider had not addressed. Mr Snow's family were not invited to the review, although a family member had been actively involved with him for some time.

Although Mr Snow lived at Bedrock Court his review was carried out at Bedrock Lodge. Mr Snow's Reviewer arrived at Bedrock Court but found no one in. He was redirected to Bedrock Lodge and told "*all reviews are conducted at Bedrock Lodge as they held the paperwork there*". The reviewer met Mr Snow in a meeting room, he did not see Mr Snow's actual accommodation or the rest of the premises. The Reviewer found no concerns to report about Mr Snow's care.

Nightingale Care made a further telephone call directly to the Reviewer from LA "B" in November 2015 to update him on Mr Snow's wellbeing.

A second DoLS application was made in March 2013. Mr Snow was again placed on a waiting list. LA "B" appears to have been made aware of the host authority's concerns about organisational abuse at one of the Nightingale Homes on 4th August 2016.

Outside of the time in scope, it is noted that LA "B" DoLS team assessed Mr Snow in December 2016 and attended Bedrock Lodge. It remains unclear as to whether the DOLS assessor saw his actual accommodation at Bedrock Court.

In summary, Mr Snow's care and support needs were reviewed but the review was not multi agency and his family was not seen as part of the reviewing process. The failure of Nightingale Care to progress the agreed outcomes of the previous review was not challenged. There were three actions in particular relating to foot care, appropriateness of the provider being appointee to Mr Snow's finances and a referral to Speech and Language for a choking assessment. By the 2015 review these had not been actioned by the provider. There was no challenge to Nightingale on why they had not undertaken these actions identified in 2014 and no action plan for achieving these actions. These vital actions were pulled through as new actions going forward.

The Reviewer was a non-qualified worker and it is understood that there were pressures affecting the management of the team responsible for reviews at the time.

5.4 LA "C" funded one person at Nightingale Homes, Mr Summers, who lived at Bedrock Lodge and was 59 at the time of events. Mr Summer had lived at Bedrock Lodge for 12 years

in 2015. He was placed there by the Mental Health team but transferred to the Autism Spectrum Care Team in 2014. LA "C" is around 20 miles from Bedrock Lodge.

Mr Summer had a review just before the period in scope in September 2014, and continuation of funding at Bedrock Lodge was sought in early 2015 on the basis that Mr Summer's needs were being met by his current placement, and his expressing that he was *happy and settled* there. It was identified that Mr Summer had *lots of potential* to develop his independence and the Care Manager indicated his aim to monitor Bedrock Lodge to ensure this was identified and goals sought to support Mr Summer to grow and develop. Specific goals had been highlighted and noted at the September 2014 annual review.

Mr Summer was referred for assessment under DoLs in February 2015 and placed on a waiting list. A Best Interest Assessor visited him in June 2015 and identified that Mr Summer had the capacity to make decisions about his own care and treatment. The BIA was concerned about some of the observed practices at Bedrock regarding restriction, use of "traffic light "charts to manage Mr Summer's behaviour, lack of access to his own alcohol, and the staff's understanding and use of the MCA 2005. The DoLS team discussed these concerns with Mr Summer's care manager and a joint visit was planned to Bedrock to discuss these issues in September 2015. Whilst the DoLS senior practitioner and care manager had some concerns about MCA practice at Bedrock, "*neither had reason to feel concerned about Mr Summers 'safety or well- being'"*. Concerns about understanding of MCA and DoLS by the provider were expressed to the Learning Disability commissioning team in LA "C" by email in September 2015. The care manager met with a staff trainer/support worker from Nightingale to discuss these with reference to Mr Summer in early November 2015, the care manager shared feedback from this session with LA "C" DoLS team and also emailed colleagues in the learning disabilities team in the host authority to ask who the relevant CQC inspector was for Nightingale. At no point did LA "C" contact the equivalent DoLS team in the host LA to share the concerns with them. In June 2015 the host local authority DoLS team was concerned about the attitude of Nightingale staff to MCA/DoLS training, information sharing with a placing authority would have provided a useful window on how staff attitudes were being reflected in practice.

Mr Summer's care and support needs were reviewed again in early December 2015. Some preparation had gone into this review, Mr Summer had been sent a letter to advise him of the review, but whether his family would attend had been left to him and Nightingale Care to arrange. It is unknown whether his family were considered or invited to this review. None of the actions agreed in the 2014 review had been undertaken. The review set expectations about the support Mr Summer needed to develop some independence skills, including support to manage his own finances. The LA "C" author comments "*The Review offers a picture of poor practice at Bedrock Lodge which is not client centred. An opportunity to set an early follow-up service user review could have been taken*". Mr Summer was unable to be independent in a number of areas, it was identified that his finances were controlled; he

had no ability to freely come and go; no opportunity to make himself a hot drink or to prepare and cook foods. These concerns were not shared with the host authority.

The Care Manager emailed the LA "C" Commissioning Team to inform them of the annual placement review outcomes. The Community Learning Difficulties Team in the host authority contacted the Care Manager to share contact details of a host authority social worker who was connected to the concerns being expressed elsewhere about Nightingale Care in late December 2015. The Care Manager does not appear to have contacted this social worker but did contact the CQC Inspector for Nightingale Homes in late January 2016 to share his concerns about the lack of understanding of MCA, DOLS and Best Interest decisions at Bedrock Lodge. It is reported that "*CQC shared their same concerns and agreed to speak with (host LA) DOLS Team about possible further input*". It is unclear why LA "C" could not speak with the host LA DoLS team.

The Care Manger sent a feedback form to the Learning Disabilities commissioning team in LA C detailing concerns about the quality of care at Bedrock Lodge. He also initiated a referral to an Advocacy service to support Mr Summer. The service took almost four months to arrange, but an Advocate did visit Mr Summer on six occasions during 2016. After the initial visit the Advocate contacted the care manager say that "*No concerns relayed from (Mr Summer) who appeared happy at Bedrock Lodge and keenly stating that he did not want to move from the home. Mr Summer also reported as not wanting advocacy to continue".* The sessions with his Advocate were intended to provide an opportunity for Mr Summer to share any worries but either he chose not to or could not do so, possibly due to being unable to conceptualise a different way of living or knowing what 'different' might look like. He had lived at Bedrock for 12 years and would have had no experience of a more enabling way of receiving support. The Advocacy closure report highlighted the level of Mr Summer's institutionalisation.

The care manager emailed Nightingale Care to follow up on some of the 2015 Review specific agreed outcomes in June 2016. They received a dismissive response from Nightingale Care.

LA "C" received notification of concerns about Nightingale Care on 8th August 2016 and were already considering whether he should move to a new placement with less restriction.

In summary, LA C reviewed Mr Summer's care and support needs thoroughly and challenged the Provider's failure to progress agreed actions. They were concerned about the standards of practice in the homes and took action regarding this, escalating within their own and their commissioning organisation and meeting with the provider's trainer. At no point did LA C share their concerns with either the DoLS or Adult Safeguarding team in the host authority, teams that would be placed to effect more urgent action to address any risks to all adults in the Nightingale Homes.

5.5 **LA "D**" funded five people in Nightingale care during the time in scope. LA "D" is around 30 miles from the Nightingale Care Homes. LA "D" is an integrated service combining both the mental health trust (AWP) and adult social care. The five people reviewed were eligible for both Reviews of their placement (Care Act or Community Care Act) as well as regular reviews under the Care Programme Approach, a pathway used to coordinate the care of people with complex mental health needs. LA "D" explains how it interprets the difference: "*A Care Review is a review of the placement to see whether it is still meeting the Service User's needs and that the placement is delivering the care that has been commissioned. The CPA (Care Programme Approach Review) is a holistic approach looking at "What the Service User needs are". Where are they going e.g. working towards Recovery and being able to manage their own mental health needs? What are their needs - is their mental health deteriorating or improving? This should be linked to the Care Plan e.g. their goal might be to remain independent. A care plan should be developed setting out the Goal. Explaining what steps are needed to achieve that goal and who needs to do what to support the service user in achieving the goal"*

There is a risk of confusion between the two types of Review, as in several cases, perhaps because of how they are recorded, they appear to have been carried out by the same person.

Ms Saunders moved into Bedrock Lodge in 2000. She was 63 years old at the time of events. Ms Saunders had an annual placement review in July 2015. She is recorded as having limited capacity to participate. She is described as "*looked happy, well dressed / hair looking clean.... goes out regularly with staff takes her meds as prescribed and appears happy in mood".* Ms Saunders was also on the "Care Programme Approach" (CPA) as a person with severe mental health issues.

She had a CPA review in November 2015 with her care coordinator present. Ms Saunders was present but not able to participate. It was noted that "*she did not appear distressed or upset at the Home". "Discussion with staff suggested that there are no unmet needs that have been identified*". A referral had been made to Speech and Language Therapist some years previously and some assessment undertaken. Ms Saunders was reported to spend much of the time "*in her own world*" chatting to herself. It was very hard to understand her verbal communication, "*It was felt that Bedrock Lodge were meeting Ms Saunders' complex needs well*". On the same day Ms Saunders also met with her new social worker for an "initial assessment"

On 4th April 2016 Ms Saunders' Reviewing Officer visited her and went through her care and support plan. The reviewer believed that Ms Saunders was *happy* at Bedrock Lodge, in the absence of her verbal communication only observation and the reports of others could substantiate this. Ms Saunders was seen for health checks (e.g. cervical smear) and minor ailments by her GP surgery and appears physically well during this time.

LA "D" also funded Mr Reynolds at Bedrock Lodge, he had lived there since 1999 and was 59 years old at the time of events. Staff at Nightingale Care consulted Mr Reynolds' GP regarding chest pain in May 2015, they were advised to take him to hospital but there is no evidence that they did so. Mr Reynolds had monthly blood tests because of the type of medication he was on, the health care assistant had no concerns about his wellbeing. He met with his new Care Coordinator in July 2015, they met alone, Mr Reynolds said that "*He likes Bedrock Lodge and the staff. What works well: Living at Bedrock Lodge, receiving support from the staff. Taking part in group outings. Compliance with medication. Regular reviews by Consultant. Annual reviews by the Recovery Team.*
**What did not work well: Feeling unsupported by staff".*
There was no detail on what feeling unsupported by staff meant. Having only met his new care coordinator once Mr Reynolds was discharged to the more local Recovery team. "*Mr R's notes and care plans are relevant, current and appear to reflect Mr R's input. Mr R appears to enjoy living at Bedrock Lodge. Plan: Continue with regular reviews"*
On 27th May 2016 LA "D" was notified by the host LA of a reported adult safeguarding concern, Mr Reynolds had been given the wrong medication, his GP was reported to have no concerns and the matter was reported to be addressed by a plan for staff training.

Mr Spry lived at Bedrock Lodge and was 54 years old. He had lived at Bedrock Lodge for seven years at the time of events. Mr Spry had an annual review on 10th July 2015, his and his family's views of the placement were sought. It was noted that Nightingale staff and Mr Spry's family had worked together well to reduce his anxiety, that his self-harming behaviour had decreased, the reviewer saw Mr Spry's room which he had just tidied and was pleased about. On September had a CPA review and was quoted as "*very happy at Bedrock he feels as though he wants to stay there as long as he can".*

In December 2015 the host authority received a concern from a student who was working at Bedrock Lodge and alleged that members of the owner's family had harmed Mr Spry. LA "D" did not attend the meeting about this and did not record the outcome of the enquiry or meeting in Mr Spry's notes, simply adding the meeting minutes. A host authority social worker followed up the concerns, speaking with the student's college and asking Nightingale to investigate. No follow up visit was made to Mr Spry by LA "D" to ascertain his wellbeing and the outcome of the enquiry made by the host authority was not recorded by LA "D". Mr Spry was visited by both LA "D" and a representative from the Clinical Commissioning group in late March 2016, but it is not clear if he was seen. Another adult safeguarding concern was received by the host authority in June 2016 regarding allegations about the ill - treatment of Mr Spry by a family member of the owner. LA "D" was invited to attend a planning meeting the same day but could not do so with "*short notice*". The host authority investigated over a period of three months, interviewing Mr Spry and working with other agencies. Mr Spry was interviewed in the presence of a member of Nightingale staff, which may have been a good support for him, or may have deterred him from speaking freely. He did take the social worker to see his bedroom which she noted as "*tidy and organised*". LA

"D" was also spoken with as part of the Enquiry and stated that they had not witnessed anything of concern to evidence the accusation. LA "D" did visit Mr Spry on 13th July and noted that "*Mr Spry states he is very happy at Bedrock loves going fishing, gardening and other activities. He says that he feels the staff help him a lot and support him to attend computer courses. He goes on to say that he sees his mother every 2 weeks also goes to watch Bristol Rovers with his father in the season"*. LA "D" did not receive minutes of the Adult safeguarding meeting and have not recorded what the outcome of the S42 Enquiry was.

Mr Hatfield had lived in Bedrock Mews for seven years and was 64 years old at the time of events.

Concerns were raised with the host authority Adult Safeguarding by the Ambulance Trust, SWASFT, about Mr Hatfield's care in June 2015. It was alleged that Mr Hatfield had slurred speech and abnormal behaviour since 8pm the night before an emergency hospital admission. Night staff had not called the Out of Hours GP service, or called for an ambulance. When the day staff arrived at 9am 111 was called for advice and following this an ambulance was called. Mr Hatfield had the symptoms of a stroke. SWASFT staff thought that the two members of staff on duty appeared "*poorly qualified*" to help Mr Hatfield and could provide very little information to staff on scene. The staff who came with the patient knew little about the patient despite working there for over a year. SWASFT reported that the residents in the home seemed unsettled and agitated by the lack of management and consistency across the home.

The subsequent s42 Enquiry lasted from June 10th – July 31st. The host authority recorded "*Funding authority informed of the investigation and outcomes*" but LA "D" have no notes about this and have not recorded that Mr Hatfield was the subject of a S42 enquiry. Mr Hatfield's CPN followed up his wellbeing and referred him to a psychiatrist to review his medication in view of his increased frailty. The CPN worked with Mr Hatfield's sister to help to manage the situation. Mr Hatfield had no Review of his care and support needs since his placement, by LA "D". Potentially as a consequence in October 2015 it was discovered that he was being charged for his care by LA "D". As a person who had previously been detained under Section 3 of the Mental Health Act 1983 he was entitled to "Section 117" funding at no cost to himself. In November 2015 Mr Hatfield's CPN was consulted by LA "D" as to whether he had the capacity to manage such a large sum. The CPN arranged for Mr Hatfield's capacity to be assessed by a psychiatrist, it was ascertained that Mr Hatfield did not have the capacity to understand or manage his money, and so the CPN gave a recommendation for the matter to go to the Court of Protection "*I shall inform the local authority, who will need to investigate the need for court of protection".* There is no record with in Mr Hatfield's notes that LA "D" in fact took this step.

Lastly, LA "D" was responsible for Ms Liverpool who had lived at Bedrock Lodge for almost seven years and was 51 years old at the time of events. In January 2015 Nightingale care

staff contacted the Mental Health Recovery team to report that Ms Liverpool was distressed about some concerning family news and had been self-harming more often, advice was needed. Nightingale Care were advised to contact Ms Liverpool's' psychiatrist and did so promptly. The Mental Health Intensive Support team in the host authority area were alerted by the Recovery team and offered support to Nightingale staff. This offer was immediately taken up as an appointment with the psychiatrist was not available until some three weeks later. Nightingale staff also reported their concerns to her GP who made a referral to NHS counselling services. Staff reported finding Ms Liverpool with a dressing gown cord around her neck, they also spoke with a clinical psychologist and received support from this service. Ms Liverpool was seen by her psychiatrist as arranged on 26 January 2015 and reviewed again a month later. She was still distressed, and a referral was made to the psychological therapies team. In April she was seen again by her psychiatrist who noted some improvement in her mental health as her family members health was also improved. In January 2015 Ms Liverpool also developed a painful and unpleasant physical ailment.

On 4th June 2015 the host authority received a safeguarding referral from Nightingale as Ms Liverpool had self-harmed. The host authority established that actions were being taken by both Nightingale and mental health services to support Mr Liverpool and no further action was required under the s42 duty. The host authority notes said that LA "D" have been informed, but there are no recordings on the chronology of either LA to document this communication. LA D did consider reviewing Ms Liverpool's care and support needs and how they were being met but decided not to until Ms Liverpool had attended a number of difficult hospital appointments relating to her physical health. LA "D" have not taken note of the specific arrangements made to monitor and support Ms Liverpool during this time of crisis in her mental health and life. Ms Liverpool had planned surgery at the local acute trust on 3rd July 2015. LA "D" went to see her for a Review on the 10th July but she had been admitted to hospital again that morning flowing a "suspected stroke". In the event Ms Liverpool had sepsis and bowel issues. She became very ill and spent a month in intensive care, during which time the medication for her mental health had to be stopped. She spent a further three and a half months on an acute hospital ward. During this time LA "D" followed up her wellbeing monthly. Ms Liverpool had a CPA Review whilst still in hospital in October 2015. She is reported to be anxious to return to Bedrock Lodge and felt "abandoned" despite daily visits from Nightingale staff. On December 2nd LA "D" Reviewed Ms Liverpool's care as she was now back at Bedrock. The Reviewing officer recorded her concerns after the conversation "*Ms Liverpool having a prolapse and her refusing to eat solids (malnutrition). The District Nurses not continuing the injections as they have been prescribed for 6 months and asking the Staff at Bedrock to do them. Also, her fear of going back into hospital (the feeling of abandonment)"*

Ms Liverpool needed a daily injection of anti-coagulant following her long stay in hospital. Initially district nurses were administering this but Nightingale staff said they could do this, that the assistant manager and staff were trained in undertaking sub cutaneous injections.

Ms Liverpool had lost trust in Nightingale staff and the Reviewing officer noted her distress. A second Review was carried out on the 8th December in a joint visit with a health colleague. This time Nightingale staff stated that they could not undertake the injections and were not trained to do so. The Review concluded that Ms Liverpool had no nursing needs, but she was not eating a good diet and would be referred to a dietician. She had a CPA review in December which reinforced her wish to stay at Bedrock Lodge. Ms Liverpool is recorded as saying "*I am able to talk to the staff at Bedrock if I feel unwell I ask for additional support. The staff at Bedrock have been very supportive after my Father's death also my long stay in hospital I can confide in staff around my thoughts and feelings. I feel safe…Ms Liverpool is requesting to stay at Bedrock where she has formed a good bond with staff"*

On 14th December 2018 LA "D" record that Nightingale had rung to say that Ms Liverpool had had a fall Saturday and the District nurse "*looked Ms Liverpool over*" but had not found any serious injury, the following day she was admitted to hospital with a ruptured spleen. LA "D" contacted Bedrock daily for updates. Neither the local acute trust or LA "D" made a safeguarding referral regarding this injury. Ms Liverpool had her spleen removed. Nightingale staff did report this incident to the host authority adult safeguarding service the same day. The host authority contacted LA "D" although LA "D" has no note of this conversation. LA "D" became concerned about Ms Liverpool's injuries and contacted CQC with their concerns on the 22nd December. LA "D" have recorded that they became aware of the host authority's concerns through their conversation with Nightingale's CQC inspector. On the 8th January 2016 the host authority initiated a safeguarding enquiry. From 13th January both LA "D" and the host authority safeguarding service kept in touch with each other and shared information. Ms Liverpool was able to give her account of how she fell, and a hospital consultant later confirmed that, given Ms Liverpool's medical history, she was likely to have sustained such a severe injury from a minor fall. Although the host authority has recorded this information, LA "D" has not recorded the outcome of the enquiry undertaken by the host authority.

During this latest hospital stay LA "D" kept in touch with hospital staff and undertook a joint visit with Nightingale staff to see her, Nightingale staff reported to LA "D" on the 3rd and 13th January that they were visiting daily, and Ms Liverpool was recovering. Nightingale staff are also recorded as providing transport to Ms Liverpool's mother once a week so that she could visit her daughter in hospital. LA "D" asked the hospital to complete a physical health screen before Ms Nightingale was discharged. Ms Liverpool was discharged on the 2nd March 2016. She had the support of the hospital psychiatric liaison team throughout her stay. Her GP thoroughly reviewed her physical health on the 7th March, noting that although she looked unwell her observations were on that day normal. She would continue to be visited by a district nurse.

On 10th March 2016 BrisDoc received a request from the haematology laboratory to contact Ms Liverpool following a blood test. The test showed an abnormally low haemoglobin level in a "*patient who had been extremely unwell and had spent a long spell in ICU*". The GP was

unable to contact Bedrock Lodge using any of the telephone numbers on file. It was decided that the bloods results were serious, and that the patient needed to be seen that evening. A home visit was therefore arranged. The visiting GP knocked multiple times on each of the three buildings and tried all the telephone numbers again but was unable to get a response. The lab results were therefore telephoned through to the patient's surgery the following morning for following up. The GP arranged for Ms Liverpool to attend hospital to follow up the reason for low haemoglobin and she was admitted but discharged the next day. Her GP undertook a home visit on the 15th March to review her health and wrote a letter to the general surgeon at the hospital to update on events since discharge. At the same time the GP sent an "*Urgent fax to South Gloucestershire Mental Health Primary Care Liaison regarding pt deterioration in mental health and unwillingness to engage in basic hygiene measures as raised by care staff".*

Ms Liverpool was taken by ambulance again to hospital on the 22nd March in great pain. She was discharged that day but re admitted on the 25th March with bleeding, discharged the next day.

LA "D" saw Ms Liverpool at Bedrock on 29th March 2016 and noted that she was now on the ground floor, walking with a Zimmer and attended by a district nurse daily. LA "D" convened a multi-agency meeting with District nurses, a District nurse manager and Nightingale staff. A plan was agreed for her to stay at Bedrock, staff were asked to monitor her bowel movements, weight, fluids, and diet. She had an internal infection and was sleeping in a downstairs room with a call bell and awaiting a "stairs assessment".

Ms Liverpool was seen again by a different psychiatrist on the 14th April who felt that her mental health was improving. Sadly, Mrs Liverpool's mother died on 21st April. Nightingale staff confirmed that Ms Liverpool would be treated as "High Risk" but LA "D" have not recorded what this meant, what the risks were or how they were to be addressed. Ms Liverpool still had a drain and Pic line in situ following her operations. Her GP held a multi-disciplinary meeting on 23rd May as the district nurses were concerned about Ms Liverpool's falls. Ms Liverpool was seen by her psychiatrist again on 21.6.16 and 2.8.16, accompanied on those occasions by the Nightingale owner.

Primary care staff have noted their concerns about Nightingale's ability to care for Ms Liverpool given her physical health at the time. She was determined to stay at Bedrock, and staff agreed that they could care for her, although as above, were able to say that they were not trained to give sub cutaneous injections.

In summary, people being funded by LA "D" received an inconsistent response, Mr Hatfield had no Review despite the deterioration in his health and concerns about Nightingale staff's ability to react to any rapid deterioration. LA "D" responded with attention to Ms Liverpool's continual and concerning deterioration in her physical health and convened a meeting with primary care staff to address physical health concerns, concerned perhaps at the impact that leaving Bedrock would have on her mental health. No risk assessment of the potential

for her physical health needs to go unaddressed appears to have been made, or consultation with her mental health team.

The Reviewing team in LA "D" was set up in April 2015. The staff were experienced but non-qualified and are reported to have "*needed good training*" for their new role. Initially the Reviewing Officers were not sure of their role or what was expected of them, they had no clear guidance on these matters.

5.6 Host LA

The host LA funded three people at Nightingale Homes. Mr May had lived at Bedrock Lodge since he was 21 years old. He was 40 at the time of events. His care and support needs were reviewed in March 2014 at which time both Mr May and his mother, who also attended the Review, were recorded as "*happy with the support provided, the placement and with (Mr May's) progress; no concerns raised*". Mr May was due to be reviewed again in March 2015 but this was delayed because of "*lack of Staff / Departmental Time*". His review happened outside the scoping period, in October 2016. Mr May was referred for an assessment under the Deprivation of Liberty Safeguards in February 2015 and placed on a waiting list. The application was reprioritised in August 2016 following the host authority's concerns about the potential organisational safeguarding. Mr May was found to have the capacity to make decisions about his own care and accommodation. During this period Mr May was experiencing some issues with his mental health and was re referred by his GP to the mental health services, he was seen by a CPN in January 2016, his increased anxiety was felt to be as a result of a *"new resident"* at Bedrock Lodge and *"changes" there.* It is not specified what these were. His GP continued to review, and support Mr May and he was frequently visited by his family. Mr May is said to have developed far more independence in his new placement and is contemplating a move to supported accommodation.

Mr Green lived at Bedrock Lodge and had first been in contact with Nightingale via his attendance at "day care" for three days a week. He began living at Bedrock Lodge in 2001 when he was 56 and was 70 years old at the time of events. Mr Green had no Review of his care and support needs during the time in scope. It was noted by the agency author that Mr Green had last had a review in January 2014. His family were not present, and no contact was made with them to ascertain their views despite them being in frequent contact with him. He was referred for an assessment under the Deprivation of Liberty Safeguards in September 2015 but was assessed in March 2016 having been "reprioritised" due to use of medication that may constitute a restriction and the period he had spent on the waiting list. Mr Green's deprivation was authorised, he did not have the capacity to make decisions about his care and accommodation.

The host authority has reported that operational factors such as period of limited capacity in the social work teams to conduct annual reviews within the required timescales resulted in an extended period when there was no checking that the Nightingale Care was meeting the

needs of Mr Green and Mr May. In addition, it is reported that the reviews carried out prior to the period in scope did not meet the agency expectation of a person-centred approach.

Ms Franks lived at Bedrock Lodge and was 68 years old at the time of events. The host authority had a duty to provide advice and guidance to Ms Franks and her family but, as her care was "self-funded" had no duty to assess or review her care and support needs. The host authority was also responsible for undertaking Deprivation of Liberty Safeguards assessments and enquiring into any adult safeguarding concern. Ms Franks family report that they were closely involved in her care and had a power of attorney for welfare and finance. Ms Franks was referred to the Deprivation of Liberty Safeguards team in February 2015 by Nightingale and placed on the waiting list. A second application was received from Nightingale in March 2016, the DoLS team proactively followed up, gathering information that raised the priority of the application from high to urgent as Ms Franks was being treated with "*psychiatric medicine*" (sic) and had been on the waiting list for over a year. The DoLS assessments were completed on 29th April 2016, Ms Franks family were consulted and reported as happy with the care and support given to Ms Franks by Nightingale. No concerns were noted about Ms Franks care, the environment or care given to others.

The host authority had other contacts regarding Ms Franks, a fall was reported by the provider in December 2015, she was taken to hospital and had a urine infection. The host authority established that she was self-funding at this point but did not make any attempt to identify or contact her family. In June 2016 Nightingale reported that Ms Franks had gone missing during a trip to the circus and was found after the police were called, the host authority established that the staff ratio during the outing was 3:1 and further actions to prevent such an occurrence happening again were planned. No further action was needed.

Again, in June 2016 the host authority was notified by the provider that Ms Franks has been admitted to hospital on 23rd June following ten epileptic seizures. She had not been taking her medication and her GP had recently prescribed a liquid form to try to ensure that she could do so. The host authority followed up by making enquiries about whether she was known to the mental health team and established that she had been seen by the memory clinic 18 months previously. No further enquiries were made, and Ms Franks family were not contacted. Ms Franks Deprivation of Liberty authorisation lapsed after a hospital admission after a fall and was renewed on 20 July 2016 for another year following her discharge from hospital. The renewal was done on the basis of "equivalent assessments", i.e. her previous assessments were still legally valid. No visit was made to the Home.

Ms Franks GP actively addressed concerns regarding changes in Ms Franks behaviour in February 2015. She was referred to the memory clinic and a CT scan undertaken, further medication was prescribed. In December 2015 Ms Franks is reported to be not eating much, she had previously been prescribed supplementary foods but was not keen on these either. She was bought to the surgery by a carer in early January 2016, but no obvious cause could be found for her disinterest in food, it was thought to perhaps be part of her dementia. She

was seen again in the surgery in late January, still not eating and Nightingale staff were concerned that she was not taking medication for epilepsy. The carer who attended with her reported that Ms Franks would take her medication if she was present, but not for other carers.

Ms Franks' GP notes record that Ms Franks had attended a fracture clinic at the local hospital on 25 May following an unwitnessed fall in the garden of Bedrock Lodge. She had fractured her arm. The clinic was concerned about bone density. The ED follow up letter of 2 June 2016 stated that her fall had been witnessed and occurred when she was leaning to pet a dog. The incident had not been reported by the provider or hospital to the host authority. On the 6th June Ms Franks was put on liquid medication as she was no longer accepting her medication in its previous form.

By June 2016 Ms Franks had begun to lose weight rapidly, "*a stone in six months.*" Her GP previously recorded that she usually weighed "40 kilos" which is just over 6 stone. Did Ms Franks now weigh 5 stone? She is recorded as "*not eating well but on protein drinks*"

On June 14th she was seen in the GP surgery, she had a period of speech disturbance that day but now seemed well. The GP gave advice about what to do in the event of a recurrence as the symptoms might suggest a TIA. Ms Franks was reported by her carer to no longer take medication. On 22nd June Ms Franks was reported to have had another fall, GP gave advice. On 28 June the GP received a letter from the Consultant at the local Stroke Clinic recommending referral to a dietician. On 23rd June as above Ms Franks went to ED having experienced prolonged epileptic (status epilepticus) fits. After discussion with her carers about "Admission avoidance" she returned home. A Do Not Resuscitate (DNAR) was in place at the hospital and the GP asked to review her care in two weeks, a clinical pharmacist reviewed her liquid medications, entering into a dialogue about what was working with Nightingale staff who were also able to contact him for advice, and did so. On 12th July Ms Franks is recorded as fainting at the Home, her GP was concerned about any relationship between her fainting and her epilepsy medication.

In summary, Ms Franks was becoming much more physically frail during the time in scope. She appears to have a diagnosis of dementia, she is not eating and has falls, faints, potential TIAs and fits, the latter perhaps caused by no longer being able to take her medication. The picture is one of complexity but there appears little discussion with her family or consideration about whether carers at Nightingale can support her. One carer could get her to take medication, the rest are reported to not be able to do so, despite Nightingale staff getting help for Ms Franks whenever needed it does not appear that they were able to address her changing needs.

Mr Wise lived at Bedrock Mews and was 58 years old at the time of events. Mr Wise is funded by the host authority but does not appear on their report as his care and support is managed by the mental health trust as part of a section 75 agreement between the LA and the NHS. Mr Wise had lived in two of the long stay hospitals for people with mental health

issues for over twenty years before he moved to Bedrock Mews, the first care home he had lived in. He had lived at Bedrock Mews for twelve years at the time in scope. In contrast to those funded via local authorities, Mr Wise had frequent contact with his social worker. Mr Wise was seen by his social worker in January 2015. He said that he was "*happy*" at Bedrock Mews but did think about moving on but was unsure there would be many places to accommodate him. Mr Wise made two calls to his care coordinator in February 2015, in the first he said that he was "*unhappy at having to work with animals in the cold whilst at day care at Bedrock*". In his second phone call he said he didn't feel the residents were given enough food. He followed up with a further message, he was not getting enough food and drink. "*The guys are on a tight budget. Doesn't feel wanted. They are making him do physical work and it doesn't seem right"*. Mr Wise also telephoned the police to complain about his treatment at Bedrock on several occasions. In March 2015 Mr Wise organised a petition with other people living at the Nightingale Homes to demand bigger portions, he reported that he was not listened to but called a "*militant*". Mr Wise's social worker called a CPA Review in March 2015 which his psychiatrist and Nightingale staff attended. Mr Wise said that matters had improved but later contacted his social worker "*not happy with his care manager taking him to and attending review. Didn't say what he wanted to say because she was there. Thinks other people speak for him and won't let him say it himself. Care should be about what he wants rather than what everyone else thinks he should have".*

Mr Wise's social worker continued to see him regularly. She was aware of his allegedly being assaulted by a staff member in June 2015 and discussed this with him. She recorded that she was unable to get through to Bedrock Mews at certain times of day, but that Mr Wise always went to day care, she sometimes saw him there and understood that it was hard for him to talk there as other were about. He did go out alone, sometimes to walk to day care, and his social worker made sure this was risk assessed. Mr Wise had another CPA review in March 2016, it was noted that "*your support at Bedrock are pleased with how you've been doing despite your recent bereavement you have continue working at the Lodge and kept busy.*
You continue to engage in your routines at Bedrock Mews and the Lodge. You started walking to the Lodge and the exercise has worked well for your physical and mental health".
Mr Wise had no reviews of his care and support during the time in scope. In hindsight, his remarks about his experiences at Nightingale are coherent and pertinent, but do not appear to have been interpreted as such at the time.

The host authority commissioning team, which is interested in issues of quality in provided services, had no "rolling programme" of visits to Care Homes at the time. They have noted that recommendations to the Provider were made after a financial audit in 2006 but were not followed up until 2016. With no information of concern from either their own authority or others they had no reason to prioritise a visit to the Nightingale Homes.

5. 7 Analysis: The Placing Agencies

A key question for the Review is "*Were concerns noticed by practitioners within the scoping period"?*

Placing Authorities might notice concerns when visiting the premises, observing staff and other residents as well as the person they had come to see. Very few visits were made to the premises, some visitors were only permitted to see Bedrock Lodge where reviews were held, allegedly because all records were kept there. But within the scoping period ten people had no visit from their placing authority at all.

Placing authorities appeared to be experiencing severe capacity issues (LA "A" and host authority) or were adjusting to new structures post reorganisation (LA "A" and LA "D") Local authorities did not meet the legal, or their own policy expectations, in all cases.

Placing authorities might pick up concerns from family members, but families were rarely invited to Reviews and their contact with the person at Nightingale or thoughts about the placement were not understood.

The failure of the Provider to follow through on agreed outcomes was only challenged by one authority. Often reviewers would comment on whether the person seemed "*happy*" or not. Did Placing Authorities have low expectations of the people they had placed regarding the development of independence?

Reviewing teams rarely consulted other agencies or arranged multi agency reviews where concerns could be understood and shared. The Mental Health Trust was both relied upon by some authorities, e.g. LA "A", but omitted from information gathering and consultation. People who had complex needs and people who had been settled for some time were reviewed by non- qualified staff who may not have the competence to identify and plan complex responses to need, or to challenge carers who might have been providing services to an individual for over 20 years.

LA "A" had placed a number of people it considered "*hard to place*" and could acknowledge that the placement was not suitable for, in particular, Mr Smith and Mr Jones, but avoided dealing with the consequences of this.

Placing authorities may have differed in what they considered a "concern". For some there seemed to an acknowledgement that people were settled into a routine and were attached to staff and the institutionalised practices at the home. Predictability and reliability together with warm relationships with staff kept people "*happy*". There was little professional curiosity about daily routines or indeed the wider domains which make up a person's sense of "wellbeing", it is unknown whether documents, including care plans or risk assessments were viewed by reviewing staff, a few are commented upon by placing authorities and other agencies (*see below*) as of good and useful quality, but are usually not mentioned and potentially not seen.

Information which indicated concern was picked up by each of the placing authorities at some point during the period in scope. None of the placing authorities shared this information with the host authority adult safeguarding team, commissioners or Deprivation of Liberty safeguards team. When the people they were responsible for were subject to adult safeguarding procedures there was very little involvement from the Placing Authorities. ADASS Out of Area Safeguarding Adults Arrangements (2016) specifies the roles of placing and host authorities. Whilst the host authority has the duty to enact a s42 enquiry, the placing authority has the responsibility to check the person is safe, that their needs are still being met, and that the Provider can continue to ensure the safety of the person. In the majority of situations within this Review the placing authorities have not followed these ADASS agreed protocols. One author has commented "*With the host authority coordinating the safeguarding responses there is an inherent risk that placing authorities are distanced from safeguarding outcomes. This could be because the placing authority puts too high a responsibility on the host. Alternatively, information may not always be shared*".

A Second key question is "*What were the barriers to sharing concerns about practice at Nightingale Care within the scoping period*?" Local authorities "C" and "D" approached CQC with their concerns. They did not initially attempt to contact the host authority and did not appear to know who to contact. Within the South West region all Adult Safeguarding and DoLS leads know each other and have shared contacts lists. However, for reviewing practitioners and their managers information about who to contact, and the process for doing so, may not be so readily available. Staff at the Review event commented "It's *hard to know who or how to share the information with, what are the roles, responsibilities and process for sharing information, the process is and seems complicated*" If professional staff think this, how easy is it for non-professionals to express concerns?

"Silo" mentalities may also account for the failure to consider the need to contact the host authorities. Placing authorities report the experience of high volume, stressful working practices, an intensity of work which can lead to focusing only on the organisational demands of one agency or even part of an agency. In such an environment, the people placed outside of a local authority boundary may be forgotten.

5.8 Other agencies involved with the people living at the Nightingale Care Homes

5.8.1 The General Practice

All of the people who lived at the three Nightingale Homes were registered with the same GP practice. Bedrock Court and Bedrock Lodge were in the GP catchment area, but Bedrock Mews was not. If a home visit was needed to patients at Bedrock Mews they would be taken to Bedrock Lodge to see the GP. Having said this, there were no more than one or two home visits conducted by a GP to the actual premises during the period in scope. Several people had a yearly health review recorded as being at "home," this was conducted by a nurse. People were usually taken to the GP by a member of Nightingale staff. There are three occasions noted within chronologies where people did not attend as expected, on one

occasion due to “staff shortage” but generally people did attend the GP surgery frequently and when appointments were missed these were followed up by the GP surgery very quickly and successfully. GPs recorded three missed “telephone consultations” during the time in scope, a tiny proportion of the almost 100 telephone consultations recorded. GPs reported that if the accompanying member of staff was established then they would know the person well, their background and any changes in their wellbeing, if a new member of staff attended they would not have this information. GPs found that agreed actions were followed up well, within the twenty two chronologies submitted by the GP surgery one agreed action, to take Mr. Reynolds to hospital following chest pains, does not appear to have been followed up. There do not appear to have been any consequences to Mr. Reynolds from this omission. GPs were aware of appointments with psychiatrists, and had letters regarding outcomes, they referred people to diabetes clinics, Speech and Language Therapy and were aware of safeguarding issues, indeed a GP referred one concern into the host authority safeguarding team. GPs were aware of the four recorded instances of errors in medication during the time in scope, but as these affected individual patients only once, there was no obvious trend to inform any concern. GPs had copies of Adult Safeguarding minutes relating to their patients but had not been able to attend meetings, either because meetings were called at short notice, or because to do so would detract from a significant proportion of patient time, up to eighteen face to face appointments per day. The local CCG could consider how to support GPs to attend high priority safeguarding meetings.

In summary, staff from the GP surgery were rarely required to visit the Nightingale premises as most residents were able to be seen at the surgery. The GPs were concerned about the level of knowledge about the health of residents from new staff, but not from established staff. The GP surgery reports that from the limited number of visits, from various clinicians, they were not able to identify pattern of concern relating to the environment during the period in question.

5.8.2 Avon and Wiltshire Mental Health Partnership (AWP)

AWP saw eleven people who lived in the Nightingale Homes during the time in scope. For some the contact with AWP staff was regular and frequent, for example a monthly injection and conversation, for others there might only be contact for a review.

Ms Liverpool had a good deal of support from the mental health trust, with monthly meetings with her psychiatrist, two at the clinic and three at Bedrock Lodge. Her psychiatrist described Bedrock Lodge as “*a bit dirty, but no major alarm bells were ringing*.”

Mrs Wiltshire was seen on several occasions by two mental health teams who also attempted to guide Nightingale staff in how to cope with her complex needs. The visiting CPN noted that “*managing her challenging behaviour presents risks to her carer particularly around personal care interventions”* and reiterated the plan drawn up by the OT and Physiotherapist. PCLS also sent a copy of their assessment to LA “A” as the funding

authority. The visiting CPN recalled "*the allocated worker to Ms W as having an excellent rapport with her"* The visiting community physiotherapist had no "*sticking*" concerns about the care environment.

Mrs Black was seen by a psychiatrist in January 2015 and had a CPA review in March 2015. A concern in January had prompted AWP to ask Nightingale to make a safeguarding referral to LA "A". AWP were not prepared to close Mrs Black's case until they had some conformation about the outcomes of this referral, correctly referred to LA "A" as the alleged harm had occurred in their area. AWP continued to follow this up by email until a written response was reviewed from LA "A" to Nightingale, the referral was not thought to be a safeguarding matter. Mrs Black was rereferred to PCLS in December as she was increasingly anxious about the welfare of her husband. She had assaulted a member of staff and caused damage to the property. She was seen by a CPN who then followed up by telephone. It was agreed that her PRN medication could be increased when she was agitated, and her case was closed.

Mr Hatfield was seen every fortnight by his CPN. He had a CPA review in April 2015 and saw his psychiatrist for a review in July 2015, his sister and Nightingale staff attended. He had a CPA meeting in February 2016. Mr Hatfield's CPN has commented, *"To be honest, though, both the service users you mentioned seemed reasonably happy with the placement- neither complained about the staff or regime (or no more than in any other residential care home- for example not always liking the food), and indeed they seemed quite attached to particular staff members. The main thing I observed was that there wasn't much effort to maximise residents' skills- for example they didn't participate in cooking at all, even though they probably could have done. My impression was that the organisation operated with quite poor staffing levels and that there wasn't the time to facilitate such things, especially given the severity of some of the residents' disabilities. This also had implications when a resident became distressed or disturbed, and I remember on one occasion a member of staff was hurt by a resident in the middle of the night, and on other occasions a member of staff would phone in sick at the last minute and there would be just one person in the house until further help could arrive."*

Mr Blue was also seen every three weeks by a CPN and had yearly CPA reviews. It was Mr Blue's CPN who noticed Mr Blue's symptoms and asked staff to take him to see a GP ". *I spoke to home manager, and she agreed that he needs to go to GP to rule out systemic cause. She will discuss with Bedrock owner, who has apparently been reluctant to take him to GP, and will get back to me if I need to follow this up further".*

Mr Wise was seen by an AWP social worker throughout the time in scope as AWP had the delegated functions of the LA as a placing authority. Mr Wise did have regular CPAs and his medication was regularly discussed and ultimately reduced. His social worker saw him monthly. His social worker is reported to have been "*wondering who was able to make a decision about the suitability of placements at Bedrock Mews. He reflected that many*

agencies were involved, and he recalls waiting on the outcome of a pending CQC inspection. He did not think the level of concern justified immediate action or closure but recognized some low-level issues which he believed other agencies were dealing with".

AWP has identified that it was an infrequent visitor to these premises, but in fact AWP staff visited more often than any other agency, giving reliable and regular support to the people referred to them, acting at times as advocates for health treatment. The themes emerging from the feedback were that Nightingale Care Homes often took residents that were difficult to place elsewhere, and that the general level of care was considered "satisfactory" rather than good. AWP staff saw "low level" issues, for example about the cleanliness of the environment, but these were not of a degree that prompted staff to act or flag their concerns to seniors. There were comments about the staffing levels in the homes. This appears to have been the explanation for a relatively restricted range of opportunities for residents, and for challenges managing more difficult episodes of behaviour. One individual noted a number of low level issues which individually did not amount to immediate safeguarding alerts, but that there was the impression that other agencies (particularly the CQC) were already aware and teams were waiting on their report or judgement. This lack of clarity regarding 'ownership' of any action could have been considered a barrier to staff raising their own safeguarding concerns. AWP staff did note that that some staff were very caring, and engaged well with the residents. They also noted that Nightingale Care was willing to work with residents that other providers would not accept.

5.8.3 Sirona Care and Health: During the period in scope, three teams from Sirona Care and Health were visiting service users in Nightingale properties; the Learning Disability service, the Community Rehabilitation team and the GP Community Nursing team. They were involved with eleven of the people who lived in Nightingale Homes, including Ms Liverpool, Ms Wiltshire, Mr Snow, and Mr Spry.

Some staff members attended the Home for brief periods to undertake a specific nursing task. They did not know the patient's wider history, appropriately so, and were therefore inclined to think that Nightingale staff were "experts" in some aspects of care, "*Atmosphere and décor was poor, did notice locked doors but assumed they were the "experts" in managing service users with highly complex needs, so didn't feel necessary to challenge"*

Other visiting staff reported feeling uncomfortable within the Home "*Some issues with other service users' behaviour, making staff feel a little "uncomfortable", felt as if it was an "institution" rather than a home. It felt as if people were locked in, for their own safety, but it made Bedrock feel like a place you might not wish to visit on your own".* As general nurses, they had not had contact with, for example, people with learning disabilities or mental health issues, and were at sea about whether the practices they witnessed were acceptable or not. "*Community nursing service was only aware of a few service users. (Staff member) felt uncomfortable there, and was keen to visit in pairs, due to the service users feeling intimidating",*

Other nurses were more confident, "*Staff were not very knowledgeable, but they appeared to be very caring and concerned about individuals' wellbeing"*

Sirona staff did use their expertise to form a number of professional opinions, they were concerned that Ms Liverpool's health needs being too great for the setting to manage and raised these concerns a number of times, culminating in an Multi Disciplinary Team meeting in April 2016 "*felt that everyone wanted (her) to remain at Bedrock, and didn't want to hear that her care needs might have been outside of their ability to cope. Very defensive meeting, social worker and CCG involved, and action plan was put in place which was adhered to in the most part".*

Ms Wiltshire's care was also of great concern, "*DN team did feel that (she) should have been cared for elsewhere but didn't know where that would be as obviously an acute hospital would not be ideal either….*

Staff didn't feel that the mix of residents was right, but staff talked about taking them out for trips so there was a general acceptance that this was the norm, and the heightened level of noise and disruption was usual for these service users".

Sirona staff were also concerned that no one seemed to have an overall view of the health needs of residents, each professional was visiting only one for a short period. Staff did have concerns about the environment being cold. "C*oncerns raised that the house was cold, like an institution and some rooms were very bare. The house was "tired", "needed updating" and nothing was personalised, but "have been in worse places".* Staff did not identify being cold as a safeguarding issue, but one of quality, and were not clear about where to take concerns about quality. The safeguarding process is reported to be understood by staff, but not one that they felt part of, they report that they were often not aware of whether a referral sent in had met the eligibility criteria for safeguarding and were not routinely invited to strategy meetings. A nurse from the CLDT did raise concerns about Bedrock Lodge being cold with the host authority adult safeguarding team in January 2016.

Team members identified some good practices in the Homes, for example "*Keyworker xx, was excellent, she knew (x) really well, worried about how they would get appropriate investigations done with his challenging behaviour. She had a very proactive approach and was very supportive".*

"Staff appeared attentive and knew about x's care needs and appeared to have a cohesive plan to get GP to review analgesia and general condition. Care worker very involved with x"

Sirona staff felt that the carers were caring overall and supportive of individual residents although access to a manager was sometimes limited and they may have lacked up to date training and knowledge

5.8.4 BRISDOC

BrisDoc provided urgent out of hours GP services to the residents of Bedrock Lodge, Bedrock Court and Bedrock Mews when the patients' own GP surgeries were closed.

Within the time period in scope BrisDoc found fifteen consultation records spread across the three premises during the time frame in scope. BrisDoc highlighted instances which could indicate unsafe systems; an incident of medication error affecting three residents at Bedrock Lodge in 2016, although no residents were adversely affected; two instances where an out of hours Doctor was required but turned away by staff as "the patient was asleep". On one of these occasions, at Bedrock Lodge in December 2015, no one answered the door and the GP was told the visit was no longer necessary via a phone call from Nightingale staff. In March 2016 an urgent visit to Ms Liverpool could not take place as no one answered the door. Two calls to Bedrock Mews also indicated concerns, a call was cancelled in December 2015 as "the patient was asleep" and a call in August 2016 was not possible to progress as no one answered the door. These themes are only possible to see in hindsight however, they occurred in different buildings with months between them, and potentially were undertaken by different members of staff.

5.8.5 South West Ambulance Service Foundation Trust (SWASFT)

SWASFT services attended Bedrock Mews on ten occasions, Bedrock Lodge on ten occasions and Bedrock Mews once during the time in scope. SWASFT assert that this would not be an unusual pattern in a care home within the time period considered. SWASFT found "no safeguarding concerns" within each visit. However, a Safeguarding concern was sent to the host local authority by SWASFT in June 2015 after the delay in summoning help for Mr Hatfield. In addition to concerns about Mr Hatfield's treatment, the crew said that "*the residents in the home seemed unsettled and agitated by the lack of management and consistency across the home.*"

5.8.6. North Bristol NHS Trust (NBT)

Nine of the 26 residents of Nightingale Homes attended the local hospital Emergency Department during the time in scope, some like Mr Timms on one occasion, others, for example, Ms Liverpool, on six. All but two of the attendances were felt to be appropriate at the time, two could have been dealt with in Primary Care services, both occurred on a Sunday. Two of the attendances, the occasion when Ms Liverpool was found to have a ruptured spleen in December 2015, and when a distressed Mr Snow injured himself in May 2015, should have resulted in an adult safeguarding referral to the host authority. At the time no concerns were raised regarding these attendances, and even in hindsight no pattern occurs, there is no particular day or time of attendance, or type of injuries/signs of neglect that might indicate an abusive environment.

5.8.7 Avon and Somerset Constabulary

Mr Wise made a total of ten calls to the police 101 number, nine between 11 March 2015 and 12 October 2015, and one more on 15th February 2016. Three of these calls related to alleged crimes, Mr Wise reported his camera lens stolen and, in May 2015, alleged that a member of staff had assaulted him. In June 2015 he reported that a member of staff had "*squeezed*" another resident in the stomach. These calls were attended by police officers, in the case of the camera lens the incident was recorded as a crime and some investigative activities occurred to try to establish the facts. With regard to the alleged assault both Mr Wise and the staff member were spoken to, it would appear that Mr Wise had struck the staff member before being pushed out of the office. The information was shared with the host authority safeguarding team on 25th May 2015. Mr Wise withdrew his allegation regarding the squeezing of a fellow residents' stomach by a member of staff when seen. During this particular telephone call to the police he had also highlighted his concerns about the amount of medication being given to Ms Wiltshire. This was not taken up with him by the visiting officer, potentially as the officer may not have been given all information before visiting, this appears to the police author to have been a missed opportunity to look further into Mr Wise's allegations. No safeguarding referral was made by the police regarding this particular incident.

Mr Wise's other calls to the police were about conditions at Bedrock. He told the police about not getting enough food and starting a petition, about being unhappy at the Home and about staff not being qualified to look after him, restricting his money, and giving people too much medication. All the calls were linked by call handlers – except for one which had an incorrect number. Police call handlers were sympathetic, one commenting "*in view of Winterbourne View, we should attend*' and continually ascertained that Mr Wise, and other residents were immediately "safe". Mr Wise was not always focused in his conversation however, and did not only talk about his unhappiness about conditions in the Care Home but also about the government, health system etc. It was hard for the call handlers to keep him focused. After a call in April 2015 police checked with his sister and establish that she had no concerns, and that he had a mental health social worker who had recently had a meeting.

On 23rd November 2015 Nightingale reported that Mr Short had died, attending officers were concerned, noting that the building looked "*rundown and in need of repair inside and out*". They also noted concerns about "*staff training*" although the issue appears to be about the process in place for incidents, when Mr Short was found the owner was contacted rather than an ambulance and "*the owner then rang the Doctor who refused to attend and phoned police*". Concerns were also raised about the house being cold, and Mr Short's bedroom being cold with no heating appearing to be on. This information was shared with the host authority adult safeguarding team on the 25th November 2015. Police report that the adult safeguarding team asked them to follow up, and they did so on 30th November, this time finding the living areas of the premises warm and clean. No further action by any agency appears to have been thought necessary.

The next contact of significance was on 06/05/2016 when SWASFT reported to the police that Mr Brown had died. The police discussed this with adult social care, as Mr Brown had died of natural causes no further action was needed.

On 07th June 2016 a host authority social worker reported that Mr Spry had allegedly been assaulted by a member of the owner's family. Police worked closely with adult safeguarding to try to investigate this and another allegation made by a whistle-blower regarding ill treatment of Mrs Wiltshire. There was insufficient evidence to undertake a prosecution regarding Mr Spry's treatment and no other criminal matters were identified. The police noted that adult social care and CQC were continuing to

"Identify areas for improvement and they were overseeing implementation of recommendations"

On 09/08/2016 the police received a referral from the host authority regarding a staff member making threatening comments to Ms Wiltshire which also mentioned the use of "chemical restraint". This matter was being investigated by Nightingale who had suspended the staff member as no action was required by the police at that time.

Police did pass on information, expressed concerns and worked with the host local authority as appropriate in the instances described above. The police have decided to use this opportunity to improve their ability to identify premises where Adults at Risk reside, to review information on these premises quarterly and to ensure that attending officers have full information on concerns before visiting.

5.8.8 The Training Provider

A Training Provider was delivering the knowledge and assessment for a number of apprentices at Nightingale during the period in scope. Seventeen members of staff were undertaking Intermediate or Advanced Apprenticeships (Level 2 or Level 3) in Health and Social Care. Assessors would visit each learner every month with a minimum of fourteen visits for Level 2 and sixteen for Level 3. This qualification includes the Health and Social Care Diploma, which is a "portfolio-based" qualification. An Employment Rights and Responsibilities Unit and a Technical Certificate, which are portfolio based. Functional Skills Maths and Functional Skills English (Level 1). Apprentices at Nightingale were also under taking level 5 Higher Apprenticeships - Leadership in Health and Social Care, for learners over the age of 19. Assessors visit the apprentice every month with a minimum of sixteen visits for L5. Level 5 learners are expected to undertake work on their own between visits and show their development of skills over the 16 months.

119 contacts with the seventeen apprentices working at the Nightingale Homes sites were made by fifteen different assessors during the time in scope. Not all visits were to the Nightingale premises themselves, some were to the local Library. The majority of meetings with apprentices took place in the "art room", a conservatory on the main building, or in a portacabin on site. The Training Provider thought that Nightingale demonstrated

commitment to their learners by providing quiet rooms in which they could meet their assessors. The assessors carried out very few observations as part of their work and often saw the people living at Nightingale only "*from a distance*". The observations of staff activities which were carried out were reported to be "*positive*" and demonstrated sound practice. None of the learners appear to have raised concerns with their assessors, although a "student" did subsequently make a series of allegations about Nightingale after leaving.

5.8.9 Care Quality Commission (CQC)

CQC carried out a number of inspections on Nightingale Homes during the period in scope. It received information from a range of agencies involved with the people living in the Homes, and as seen below, from one relative.

CQC inspected Bedrock Lodge on the 29 January 2015 and published their inspection report four months later in May 2015. The service was rated '*Requires Improvement'* overall, being rated as "Good" in "Safe" and "Effective" but with improvements indicated in the other three domains, Caring, Responsive and Well led. Two breaches of the Health and Social Care Act 2008 were found, Regulation 11 (Need for consent); *People who use services were not protected from the risk of care being given without consent. Staff had not received appropriate training and authorisation had not been sought from the appropriate authorities regarding deprivation of liberty* and Regulation 17 (Good governance); *People were not protected from the risk of not being provided with the care they needed because care records were not consistently maintained.*

CQC inspected the Home again on 31st July 2016 to check that the provider was now meeting the regulations that had been breached. The service was rated 'Good' overall on this occasion.

Bedrock Mews was inspected on 12 June 2015 and the report published in August 2015. Bedrock Mews was found to be "Good "in all domains.

Bedrock Court was inspected on 22 December 2015 and the Report published in February 2016. Bedrock Court was rated as Good in Effective, Caring and Responsive, but Requires improvement in the other two domains, Safe and Well led, resulting in an overall "*Requires Improvement*"

Apart from the police concerns around Mr Short's death in November 2015 CQC had no other information from external sources prior to the 2015 inspection of Bedrock Court.

However, CQC did have its own internal data collections which were indicating issues prior to the 2015 inspections. Bedrock Lodge was rated as having a "*much worse than expected*" number of staff who had completed health and safety training, as was the number of staff who had completed infection control training. At Bedrock Mews the numbers of staff who had completed health and safety, infection control and moving and handling training was "*much worse than expected*", in Bedrock Court the number of staff who completed health

and safety and infection control training was "*worse than expected*". This, coupled with recognition that there was no registered manager in any of the premises, might have indicated a deeper issue with the Homes.

The inspections of 2016, outside of the scope of this review, picked up numerous concerns in all three premises as detailed in Section 4 above. How could inspections, carried out between 10 – 15 months later have been so different in outcome? There are three potentially significant areas of difference. Firstly, once the host authority had initiated the organisational abuse procedures and begun to hold multi agency meetings CQC became aware of a range of information it had not previously known. Secondly, only one inspector undertook the inspections of 2015, whilst in 2016 the inspections were informed by a team, including an inspector, an expert by experience and an expert in behaviour management. Finally, all three locations were inspected by the same team, enabling the recognition of the inter relationship between the premises and commonality of the concerns seen.

The findings about the rigidity of routine and institutionalisation of the people living in the Nightingale Homes are apparent in historical CQC inspections, "*A member of staff told us that people were used to the daily structured routines of attending day care and accepted this"* "*There was no evidence to show people had been informed about the decision to use CCTV in their homes or to get their views or consent about the use of it. We did not see any evidence of the involvement of advocates in supporting the needs of those people. We did not see records of meetings for those people who did not have capacity to make decisions and whether this was in their 'best interests*.' and "*We were told by staff that all monies were handled by the main administrative office at Bedrock Lodge, and that peoples' personal allowance was kept at the Lodge. People did not have access to their monies individually in the home. We were told by one individual that they did not know how much money they had available to spend. They were only given their bank statements when they asked for them, as they were not kept at the home*". (Bedrock Court 2011); The institutionalised practices at the Nightingale Homes had been known for some years, CQC had asked for improvements in these practices but had perhaps not followed up in detail as inspectors and inspection methodology changed.

5.8.10 Host Authority – Organisational Safeguarding Team

During the period in scope the host authority was using a system whereby if three "alerts" were received within a period of six months then the provider's service would be screened for any indicators of potential organisational abuse. The three Nightingale properties were considered separately at the beginning of 2015, and so each individual Home did not accrue enough alerts to meet the threshold for this type of screening.

The team's first encounter with Nightingale during the period of scope was a proactive visit by the adult safeguarding team and DoLS team in May 2015 following the "*Requires Improvement*" rating of the January 2015 CQC inspection of Bedrock Lodge. Training in Adult Safeguarding and the Mental Capacity Act was offered and arranged for the Home. Later

that month the team was made aware of the individual adult safeguarding concerns relating to Mr Wise saying he had been assaulted by a member of staff, and about Ms Liverpool self-harming. In June 2015 the team discussed the situation with the Sirona Community Learning Difficulties team who talked about their staff describing the Homes as "*odd*," no details were taken about what was meant by this. AWP was "*advised"* of concerns at this point but does not appear to have been asked for information, although they were the more frequent visitors to the Homes and had a good deal of information on how the Homes operated. The team was aware of the SWASFT concerns regarding Mr Hatfield's delayed transport to hospital at Bedrock Mews. The team were concerned, but asked the host authority to review all the people they were funding at Nightingale. *"Agreed reviews have been requested so more people will now be visiting. To await feedback from CQC."* As the host authority was funding two people at the Homes this strategy did not prove helpful, and in any case the Reviews did not take place. The team continued to log concerns for the rest of 2015. In November 2015 the police report that the building was cold became part of the individual safeguarding work in respect of Mr Short's death, the wider potential impact on other residents appears to have been lost, however the adult safeguarding team did gain reassurance from the police that on a subsequent visit the building was warm.

In December 2015 the team knew that CQC were about to inspect Bedrock Court, they were concerned about inconsistent accounts regarding Ms Liverpool's injuries to her spleen and a whistle-blower alert to CQC disclosed a concern about the treatment of Mr Spry by a relative of the owner. The team began to focus on these concerns into the new year of 2016 and also started to view these as concerns about "the provider" rather than about individual homes. A conversation was had with a senior manager in LA "D" in January 2016 who described visiting Bedrock Lodge and finding the service "*chaotic*" and potentially unable to meet Ms Liverpool's needs. The host authority report author has noted that according to the policy used the Provider had met the threshold for use of the organisational abuse "screening tool" at this point, but it was not used. The decision not to initiate consideration of an organisational abuse pathway appears to have been influenced by reassurance of the outcomes of the CQC inspections and a decision to delay screening while individual safeguarding enquiries were carried out. This is not part of the host authority Organisational safeguarding procedure.

In January 2016 two other agencies reported concerns about the service – the Mental Health Team advised that at a recent review the service appeared chaotic and possibly unable to meet the resident's needs, and CLDT reported that the home was so cold residents were eating lunch in their coats. No consideration appears to have been given to these reports.

By April 2016 the team had spoken with CQC, the CLDT and the host authority contracts team about the practice of sending all service users to Bedrock Lodge for day care. Record states this is "*not safeguarding as such but clearly a practice issue".* In May 2016 the team recorded Ms Wiltshire's hospital admission with sepsis and Mr Brown's sudden death.

During June the team continued to log concerns, noting that they had reached *"5 individual safeguarding alerts in the last 6 months".* Each concern was, where indicated, being pursued as a S42 enquiry. At the end of June through to the beginning of July 2016 the team began to set up the process for initiating an organisational abuse enquiry. On August 11th the team became aware of concerns about Mr Timms having frequent falls, and his brother also made a statement about his concerns regarding his brother's treatment - see section 2 below. As a response to Mr Timm's brother's concerns CQC bought their inspection date forward and visited all three Homes, initiating the actions which would result in all three Homes closing in 2017.

5.8.11 Analysis – the other agencies supporting people in the Nightingale Homes

The answer to the first key question "*Were concerns noticed by practitioners within the scoping period*"? is that some agencies did notice concerns, but not all were able to rate what they saw as a meaningful concern.

The mental health trust, AWP, had the most contact with Nightingale and had a firm grasp of many of the inherent problems. They demonstrated good practice in continually advocating on behalf of the people they saw, with the home owner and staff and with placing authorities. In the absence of action by placing authorities they problem solved as much as possible with Nightingale. AWP staff were not asked what they thought by CQC or the host authority adult safeguarding team, they were "*advised*". At the same time AWP staff were remarkably siloed in thinking that "*someone else was concerned and doing something.*"

Mr Wise was particularly disadvantaged by this thinking, his social worker was very concerned about him, but wondered who would make decisions about placements.

The community health teams were also very concerned. They picked up on the coldness of the environment, the intimidating atmosphere. The staff defaulted to the expertise of the Nightingale staff, a dangerous position to take, as they felt they "*did not know the client group*" and therefore could not trust their own perceptions. They also identified how difficult the home owner, who by then appears to be managed all the Homes, was to work with "*It was not always easy to get hold of the manager; There were quite often delays in manager getting things done. Manager also used "old fashioned" language and did not seem up to date in caring for people with specific needs. Manager was thought to be "difficult" and did not want professionals involved".*

The district nurses felt they were not listened to by other agencies and their expertise as registered nurses not valued, they are experts in health needs and their concerns, that the Provider was not able to meet a person's health needs, needed to be addressed.

All agencies, including the host authority safeguarding services, were confused about the difference between poor quality practice and harmful practice. Being cold is about harm, if a person cannot get warm, and in addition has health needs or lacks capacity, it is a risk that must be urgently addressed. Other practices, e.g. sending people to the same house for day

care could be “practice issues”, but if no further enquiry is made then the impact on people cannot be seen, if everyone goes to day care what happens to the people who don’t (they are locked in) what happens to the people who are ill (they are forced to go.)

The absence of shared information meant that concerns could not be fully explored and appreciated. CQC appear to only become aware of the scale of concerns about Nightingale Homes once the local authority began to convene information sharing meetings under organisational enquiry procedures. This highlights the reliance of all agencies on each other’s understanding and refutes the belief of some agencies that CQC alone is able to judge and declare a service good or safe.

Finally, the host authority adult safeguarding team did not have a structured method of analysing the concerns received. They were unable to pick out patterns by using a tool (for example the Hull University tool) and breached their own policies on thresholds for screening.

“*What were the barriers to sharing concerns about practice at Nightingale Care within the scoping period*?”

As above, the first barrier was recognising that a concern needed to be expressed to someone. The next barrier is about who to express the concern to. Both AWP and Community health staff spoke to their managers, a Community health manager did speak to the host adult safeguarding team on one occasion. Community health staff have spoken about their frustrations when reporting concerns directly to the local authority;

“*Staff feel that quite often safeguarding team don’t want to accept an SA1 and will try to get them not to do one, “if we do an SA1 we don’t get told the outcome of the screening or any further input unless we get invited to a meeting”. Safeguarding meetings on the whole reported as being positive”.*

Over time this will create an aversion to reporting, to “getting it wrong” and, coupled with the perceived need to differentiate between “quality” and “safeguarding” hampers open and useful dialogue between services.

5.9 Findings – The Agencies

Key question: How effectively are professionals working with adults who have care and support needs sharing information about care providers in South Gloucestershire?

A number of challenges have been identified within this Review to sharing information about care providers.

5.9.1 Not all Placing authorities are fulfilling the statutory duty to Review adults care and support needs and ascertain whether those needs have changed, are being met or can be met by a Provider. Placing authorities have not been fulfilling their responsibilities under the ADASS (2016) protocol on adult safeguarding and out of area arrangements. The absence of either contact or relationship with a placing authority means that concerns cannot be regularly identified, explored or resolved. Placing authorities began to view the

safety of an individual as the host authority's responsibility, when in fact it is their responsibility to ensure that the person is cared for safely and is enjoying the full range of Human Rights.

Placing authorities are not fulfilling their obligations to inform a host authority of people placed in their area. The host authority currently has no mechanism to capture or use this information.

5.9.2 The placing authorities did demonstrate a commitment to the person being reviewed by the same member of staff which may create familiarity. It is important that the reviewer has the expertise to address complex needs and the confidence to analyse and challenge the reasons for needs not being met.

5.9.3 An absence of relationship and for some, respect and understanding of family involvement, reduced the possibility of sharing information and understanding about the person's situation.

5.9.4 The information and input of other agencies involved with the person was rarely considered and the mechanisms to involve other agencies appear underdeveloped. The involvement of mental health services in reviews was particularly important as they are the agency which often has the most contact with the person and the provider.

5.9.5 If a person is placed in a service which may not be the best place for them, but is the only option available, a key consideration must be how the placing authority will work with the provider and other agencies, including information sharing with the host authority, to maximise the wellbeing of the person, define the indicators of success and, if needed, what can be done to identify a more appropriate placement.

5.9.6 All agencies need clarity on who and how to contact local adult safeguarding and DoLS services, this appears to be particularly vital for agencies outside the local area. LAs defaulted to notifying CQC, and in one case expected CQC to notify the host authority. This is unacceptable and over complicated communication which cannot be effective in sharing a full range of concerns with the key agencies responsible for adult safeguarding in a local area.

5.9.7 Agencies who experienced poor practice or were uncomfortable in the environment appear to have had no opportunity to reflect on what their uncomfortable feelings meant. Visiting staff were not comfortable in the environment, the people living there also found aspects of their environment stressful and distressing (*see section 6 below*). Staff must not assume that people living in an environment will not have the same reactions and worries that they have, a key question to ask oneself in any new place is, W*ould I live here, and if not, why not*?

5.9.8 Agencies were unclear on what is and is not reportable, what is poor practice, and what is safeguarding. The host authority was also unclear on this aspect of safeguarding.

These points need to be explored and clarified so that information about any type of concern can be freely shared.

5.9.9 The host authority safeguarding service does not appear to have a tool to structure its analysis of indicators of harm. Information shared is therefore not able to be fully appreciated and analysed.

5.9.10 Health staff were very concerned about the lack of "oversight" of people's health needs, similarly there was a lack of oversight of the quality of care delivered in Nightingale by those agencies commissioning care there. This oversight can provide timely information as well as resolution of concerns. The host authority had no rolling programme to look at the quality of the services it commissioned. LA "A" commissioned the majority of placements at Nightingale. Its commissioners could have undertaken inspections of quality in all the Homes.

5.9.11. Good practices have been identified in the body of the report on agencies, in particular the support given to the Provider and the people living in Nightingale Homes by the Mental Health trust and the close attention the police gave to the wellbeing of the people who contacted them and the exploration of alleged crimes against the people who lived at Nightingale. The police have shared information and challenged as needed, at one point eliciting a complaint from the Provider because they did challenge practices. SWASFT have also notified the local authority of concerns they identified. That the GP practice covering Nightingale was used by all living there – including the Home outside its catchment area- is not best practice, but the GP chronologies do show the attention the practice paid to the needs of all, from ensuring regular health checks were undertaken, including preventative checks, to undertaking thorough assessments of patients recently discharged from hospital and continually referring and following up referrals to specialist agencies. GPs are aware of adult safeguarding and allegedly referred on at least one occasion.

5.10 Changes in review systems since the time in scope

LA "A" reports that there is a dedicated Reviews workstream which is part of a "Better Lives" programme of change. This will make sure that people have timely reviews which ensure that people receiving services continue to have their outcomes met in the most appropriate way to enable them to stay as independent as possible. There are a range of different actions in place to improve in this area
"*currently we are reducing the number of outstanding reviews by around 80 people per month with a detailed action plan to get all outstanding reviews completed in the next two years, which also prioritises people who are more vulnerable or have more complex needs".*

LA "B" reports that review of the skill mix in the team responsible for specialist placement reviews has been undertaken and it was found that the team had an

imbalance of unqualified staff. When the team skill mix was aligned to those of other teams the imbalance became clear. Recruitment processes are in place to recruit two additional senior social workers to the team.

The team manager now reviews new allocations for review and ensures that they are appropriately allocated to staff with the correct skill set. Where cases are allocated to unregistered staff member (social care assessor) a senior social worker provides oversight. In addition, the team manager quality assures all assessments which are presented to panel, which provides a further level of scrutiny to the reviews being carried out.

Guidance to staff carrying out review activity has been revisited and key messages added in relation to the learning that came out of this case, for example: when carrying out reviews: what practitioners should look for; what records to request and see sight of ; application of the MCA; role of family within reviews; need to involved key agencies involved with the client within reviews. The guidance has also put in a case study which emphasises the key messages from the Review.

In terms of the wider health and social care community teams, the team managers have received a "lessons learnt" presentation and have been reminded of the need to ensure that reviews are allocated to a member of staff who is appropriately skilled to undertake the reviews. The message is that in complex cases these reviews should be undertaken by a professionally qualified member of staff.

LA C report that people undertaking reviews are now very aware of the need to use their professional curiosity when visiting an environment. This includes the consideration of whether all relevant information is being shared. If a person does not have capacity to make their own decision about the placement an IMCA is involved to confirm that the service user is satisfied with the placement. The review form for Learning Disability service users covers the issues that should be explored during a review and all staff working in that service have been reminded of the importance of its completion. Consideration is given to using this form for older people placed outside of the LA C area as well. An action plan of what LA C has learned from participating in the Review is being developed and will be revised once the Review is accepted by the South Gloucestershire SAB.

LA D now has a system to ensure review targets are met and to alert the team manager to the need to find out why the target has not been met.

The host authority has very recently (July 2018) changed the arrangements for conducting reviews of both care home and supported living placements. "Out of county" placements, i.e. those without a local postcode, are now being annually reviewed by

experienced staff from one team; placements closer to the authority are reviewed by the area teams responsible for making the placement. Ahead of this move responsible teams have worked hard to significantly reduce the number of people waiting for overdue annual reviews. There are now no out of county reviews which are more than four months overdue – with plans in place to get to a position of having no overdue "out of county" reviews by 1 January 2019.

The host authority has reminded staff that reviews must person centered and focus on the needs and wishes of the service user, and family perspectives when involved. The person's voice is heard and recorded - with support via an advocate as needed.

Reviews must focus on improving and maintaining the person's wellbeing and the achievement of agreed outcomes. Through the review social workers look for evidence that any risks are being managed and the person is being kept safe by the provider. Any concerns identified during the review about the quality of care being provided is shared with the Commissioning and Brokerage Team as well as the Safeguarding Team to ensure that a considered view can be taken on the most appropriate follow up action that may be required.

5.11 Relationship to Winterbourne View

South Gloucestershire SAB commissioned this Review five years after the publication of "Winterbourne View Hospital: A Serious Case Review "(Flynn and Citarella 2012). The terms of reference for the Nightingale Review focus on the reporting of concerns by visiting professionals, and barriers to professional and resident or family reporting concerns.

Inevitably, the Review invites a re-visitation of the lessons from Winterbourne View, what are the similarities between the two events, and what changes in practice does the Nightingale Review demonstrate?

It must be noted that the two services are very different in purpose, Winterbourne View Hospital was a private hospital for adults with learning disabilities and autism, mostly accommodating patients who were detained under the provisions of the Mental Health Act 1983. Its stated purpose was to provide assessment, treatment and rehabilitation. The three Nightingale Homes were residential care homes for people with mental health and learning disabilities. The statement of purpose published on the Nightingale Homes website stated;

"*Our aim is to provide a safe and secure environment for all our residents and to assess each one as an individual*."

Nightingale also offered "Day Care" initially to non-residents and residents, but in subsequent years only to people who lived in the care homes. The expectations placing authorities had of Nightingale changed over the years, twenty years ago the expectation

appeared to be of a home for life in which a person would be safely occupied and well cared for, latterly placing authorities had expectations that a person's independence would be increased or maintained. The expectations appear to be that the Nightingale Homes would be able to care for a person throughout their life course.

Notable features of Winterbourne View were the geographical distance between the hospital and the families and networks of the people placed there. In addition, the managing company was in another part of the UK. Commissioners were some distance away and the host authority did not use the hospital. Winterbourne View was described as having a 'closed and punitive' culture, families and other visitors were not allowed access to the top floor wards and patient bedrooms, offering little chance for outsiders to see daily routines at the hospital.

The local authorities who commissioned eighteen (of twenty-six) Nightingale placements were less than five miles from the Care Homes. The owner lived nearby and during the time in scope was acting as the manager of all three homes. Whilst the rigid routines of the Homes at times caused difficulties for some reviewing staff, professionals and families did spend time alone with the person and could note their routines. There are many accounts from professionals and families of having access to the Homes and of discussions with both staff and manager about care, and in the past of families feeling involved in care.

The features that Winterbourne View and the Nightingale Homes share are those common to all failing care organisations. In both institutions there was a failure of management and leadership, recruitment of staff who were not trained or well supervised and a lack of individualised care within a poorly maintained environment. The degree of harm suffered is markedly different, whilst there were concerns about the physical restraint of one person on two occasions in Nightingale, there is no evidence of the culture of violence that occurred at Winterbourne View.

Some of the Findings have echoed those of Winterbourne View, Mr Wise and Mr Jones, the people who spoke out about care at Nightingale were not always believed, actions were not taken by placing authorities even when other professionals reported that rights and needs were not being met. The majority of Commissioners did not regularly visit and review people's care, they did not challenge poor outcomes and they did not communicate with the host authority. In addition, a few professionals from the community health teams defaulted to the expertise of staff at Nightingale and, although concerned, thought that the Nightingale staff "knew what they were doing." A few people were placed at Nightingale when no other suitable placement could be found for them.

Other Findings demonstrate the improvements that have taken place in services post Winterbourne View. The Police responded to concerns expressed by people living at Nightingale, proactively visited the premises, checked facts with family and

professionals, and shared all information with partners using the agreed channels. In addition, the police challenged the owner and staff when concerned about the environment.

South Gloucestershire enacted its safeguarding duties toward individuals thoroughly, allocating a social worker to work with individuals directly on the Nightingale premises. Teams from the local Mental Health Trust were frequent visitors to the premises and advocated on behalf of their patients well. Once CQC and the South Gloucestershire organisational abuse team identified the degree of concern about Nightingale they were able to work coherently with all commissioners to address the situation. They were systematic and thorough in identifying the failings of the organisation and did not rely on the providers assurances as many agencies did in the case of Winterbourne View.

This Review adds to the growing body of evidence about the challenges of reviewing and monitoring "out of county" placements and working across local authority boundaries. The recommendations made will contribute to regional work being undertaken to standardise quality assurance requirement and processes, and to clarify the responsibilities of host and commissioning local authorities.

6. The people and their families. The accounts below have been taken from conversations, either face to face or on the telephone, with twelve people, and the accounts given within agency reports submitted to the Review regarding two people.

6.1 The people who lived in the Nightingale Homes

The Nightingale Homes were described as accommodation for people with learning disability and mental health issues by CQC. On their webpages Nightingale describes itself as offering "*residential care homes for people with learning difficulties, communication problems and mental health difficulties*"

6.1.2 A diverse range of people lived in the three Nightingale Homes. People were aged between 25 and 71 years old, some had lived in a Nightingale Home for over 20 years, some had recently been admitted. A group of people were already institutionalised had continued to be institutionalised as long as they lived in the routinised environment. Another group of people were deemed "*hard to place*" and often had complex physical and mental health needs. Another group of people were physically frail, and on the cusp of needing nursing care. The majority of people living in the Homes did not have the mental capacity to decide on their own care and accommodation. They were placed at Nightingale by a local authority and relied on both the provider and the placing authority to make sure their wellbeing was supported, and their care and support needs met.

6.1.3 People had some positive memories of their life at Nightingale:

"There were positive aspects to living at Bedrock, I enjoyed the annual holiday in September, the last was to Devon. I enjoyed activities that involved going out, to Filton Library, or swimming for example".

"I went fishing, with x. I enjoyed dance and movement, swimming, and I did a computer course in IT. I enjoyed going to the Pub, we used to go to the Swan. We went to the library at Winterbourne. I helped out with woodwork, I really enjoyed that".

"I did some gardening and there were farm animals. I enjoyed trips to Weston and Weymouth".

"I was a hard worker, you had to do something to live there. I cleaned out the stables, I did gardening. I was allowed to stay in the house by myself and also to walk to day care every day. I was trusted".

"I had friends there, I no longer see them as they are living elsewhere".

"Staff made sure I could get to see my husband, I was driven to (a local supermarket café) to see him on Saturdays. I am too far away now".

Members of staff, some known for years, were missed:

"I felt close to some of the care staff who were lovely, particularly my keyworker. It was a sadness to leave, I was one of the last to go. Saying goodbye to staff was hard. Staff were told not to keep in touch or see the people they had worked with. This was hard, I had known some of the staff for years. It would have supported people to make the change to have well known and liked members of staff visiting".

"Some of the staff were good, they cared about us".

"The first 4-5 years at Bedrock were good, I had just spent a long time in hospital and really benefitted from the type of care that Bedrock gave".

"I didn't want to stay in hospital when I was injured, and Nightingale staff did have me home and looked after me. I did feel secure in the sense that they would never tell me to leave the Home".

"I liked living at Bedrock and I felt sad when it closed, "I loved it there." If I was worried or unhappy about something I could go to the staff there, I got on well with three of them in particular"

6.1.4 Not all memories were positive ones:

"There were restrictions on us. Day to day life was "controlled" at Bedrock. Everyone had to go to day care at Bedrock Lodge from 10am to 3pm. The garden was huge, and residents were expected to undertake all tasks including mowing. The owners should have had a gardener to keep such a large area under control. Other activities included arts and crafts sessions. Everyone had to attend".

"I went to Bedrock Lodge for day care almost every day. I mostly did cleaning work there, mopping, hoovering, dusting, cleaning ovens and the microwave".

"I was ill and wanted to stay in bed, but had to get on the minibus and go to the Lodge. Similarly, I was ill and really didn't want to go swimming but was made to go, this was in 2011. Control extended to controlling when and how people left the premises or moved around the building. I would have to sign a form before leaving the premises. In one incident I said I was going out to vote but was told I could not go out. In the end staff held the door shut and prevented me from leaving".

"The Home was not well run, there could be bad behaviour from other residents and the staff could not always cope".

"When staffing levels were low I would be told not to come downstairs in the evenings. The kitchen was locked, some of the people living at the Bedrock Homes would not be safe in the kitchen, but there were no alternatives for people who could make drinks or meals, e.g. giving them a key. Tea was served at the same exact times during the day, no one could just make a cup when they wanted it. The place felt "controlled" not "homely"."

"The heating was off at night, so I would sleep in my clothes. Sometimes the water was off too as x, another resident, ran the water at night. Some staff did give us enough food, some did not. I think I did well to stay for twelve years as I was sometimes cold and hungry. The cameras bothered me. Sometimes there weren't enough staff and doors were locked".

"The GP surgery did not make house calls to Bedrock Court, if I needed to see a GP I would be taken to the surgery".

"We had to contribute to the minibus mileage which added insult to injury if you did not want to go out in the first place".

There were restrictions on how people could use their own money:

"We had £20 on a Monday each week to spend and then £5 on Fridays. This bought very little, by the time I had bought toiletries and odds and ends I had no money for clothes or other larger purchases. I did not know what was going into my bank account".

She was never given the opportunity to increase her weekly budget, although the DWP have subsequently told her that she could. Her quality of life was restricted not just by the control at the Home but by lack of money. Her clothes were old and falling apart. She asked her family for financial help.

"I thought I had purchased my own bed but was told that it belonged to Bedrock and had to leave it behind. Everyone received £200 back following the last holiday from Bedrock (in September 2016?) as they had overpaid. How many other holidays had been "overpaid"? "

The importance of having regular contact with a social worker was emphasised by one person

"The management would not listen to you unless you were a person of authority. I got my social worker to sort things out and I told other people to do the same".

Sometimes people felt intimidated or uncomfortable:

> *"What I didn't like, I got bullied by another person who lived at Bedrock. That wasn't right, and I didn't like it. I did tell the staff and they had a chat with the person".*
>
> *"Bedrock Court was very noisy, I kept to my room. This new Care Home feels much calmer and more relaxed although it has twice the number of people living there".*
>
> "*He described being locked in a cupboard on two occasions and this was because he did not do his cleaning tasks which were expected of him on a daily basis. He described that there were no cleaning staff employed at Bedrock Lodge and the care staff were expected to do whatever cleaning was required. He found himself required to mop floors and clean out the animal houses. He did not feel he could refuse these tasks as he would be punished. He described being deprived of food and drink and in particular his whisky was stopped*".
>
> One person simply said of Bedrock "*It was the worst place I ever lived, I was very unhappy there"*
>
> Some of the respondents felt close to valued staff members and were upset that allegedly, they were told not to visit them. This may have been police advice, rather than instruction, or may have been advice from elsewhere. Certainly, families and people the lead reviewer has spoken to were clear that Nightingale staff were told not to visit. One member of staff did visit a person when they were ill, much to the concern and consternation of their family. Another family told a member of staff that they could visit as the person was missing them so much, they had known them for seventeen years. It is good practice to ensure that people are supported by visits from known and liked staff from previous placements, it is not known what thought went into easing the transitions that people had to make as placing authorities moved them from Nightingale.

6.1.5 Analysis of peoples' accounts*;* People had key relationships with the Bedrock staff, not with their social workers or nurses. Some accounts given by placing authorities are concerned that people were not seen alone, or that they were seen alone and "*had opportunity to say something"* but said nothing. It would have been extremely difficult for people to speak out, although it must be remembered that Mr Wise and Mr Jones did, but nothing was done to help them. This would have intensified their feelings of isolation. For others they would be speaking out against the staff with whom they had the most significant relationships with, who they spent their days with. What words or concepts would they use? Without experience of different environments and care

regimes they would have no reference points to compare their circumstances with, or to provide them with words to describe what was wrong.

Some of the people had been in institutions for most of their lives, how had they been encouraged to speak out or complain over the years? Compliance or rebellion may have been their known options, many organisations, including Nightingale, have a culture of compliance, not challenge. Complaining and speaking out is a skill and requires confidence. At a recent SWADASS workshop (Making Safeguarding Personal 21st June 2018) a group of social workers and nurses were asked to reflect on their experiences of complaining, they reported that complaining about others' attitudes or a service was hard, complaining about a broken object or badly cooked meal easier, participants struggled with how to express dissatisfaction and were concerned about consequences if they had to continue to use the service. Why would we expect the group of people living in Nightingale to be able to express their unhappiness with their service readily?

How were people asked about their experiences during the short time they had with external agencies? What did they really want?

Mr Summer had an advocate during his last year at Bedrock, his advocate was very concerned about the degree of institutionalisation he was experiencing, part of that institutionalisation was that he was accepting of the service he was given and had no means with which to challenge it.

Two of the people spoken with who are now in different care homes are pleased, and surprised, by their new services. In recognising what is different they can more readily describe, from a position of objectivity, what was wrong at Nightingale.

6.2 Families

6.2.1 A few of the people living in Nightingale had no families, but many did. Families can be a support and a ready source of information, as utilised by the police when they needed an external source of information regarding Mr Wise.

6.2.2 Two of the families interviewed described the changes within local authorities and the consequent loss of relationships with social workers. "We *had brilliant social workers, they knew x and they knew his history, they knew us and how we worked as a family*".

"*They kept us informed and x really gelled with him".*

"I went to all the multiagency meetings, it was intimidating going into a room of professionals, but my sister came with me and was a good support".

But working practices changed over the years

"We *had a series of social workers who didn't get to know x well. After that x would say he had seen a social worker but they didn't contact me. Now we don't have a social worker, but that was OK as I knew Bedrock well by then*".

"We had a social worker years ago, but now we only get one when they think we need one."

Families had no relationships with named or trusted social workers. If they had concerns about Nightingale, they had no one to readily share these with. Not being invited to contribute to reviews was a constant theme amongst families. Local authorities seemed to have forgotten they existed. "*We felt that people thought that we didn't care about x which was not correct. This experience has taught me not to let things go by the board, that if I have questions I will ask them. In terms of learning, I think x Council should involve family, family are important. A person should not be placed without family being offered the opportunity to see the placement. We need to be involved and there needs to be transparency".*

"We *have a genuine interest, families need to be understood as a support network*."

Families sometimes went to Reviews with Nightingale, but the social worker did not attend these.

"The *reviews could have been more detailed with more focus on targets and things to aim for. The social worker did not attend, it would have been good to have the join up, there was no relationship between my family and the social worker. I wanted to be involved, but it's hard when you don't know who the social worker is*."

6.2.3 Families had positive experiences of the care at Nightingale, three had very positive memories of life there over many years

"His keyworker was brilliant, and when they had trips down to my area and I could see him here".

"*I felt we were working together with the owner and staff, they were flexible and helpful".*

"*X was happy there, he has to be active and there were many activities during the day, day to day care was good and the activities were varied and suited his needs. They had days out and took him to see Mum".*

"She was wonderful, she had worked there for years"

"He was looked after, the food was good, they went swimming, to the library and pub. The staff helped him be part of family celebrations, sending flowers on Mother's Day and cards on birthdays. The grounds were so extensive, there were animals, gardening and craft. There was always a party at Christmas".

6.2.4 The closure came as a complete shock for some families

"*We only heard about it in a roundabout way. Social workers were plucking people out. We knew there was a turnaround team and a re-inspection was due. We hoped it would stay open. My son so wanted to stay".*

6.2.5 Families were not always involved in how people were moved

"*We felt it was brutal, I don't understand why x had to move so fast. I got a message from his social worker "x has to move tomorrow" I didn't know where he was going. I didn't know how the decision had been made".*

"When they said it might have to close, we were heartbroken".

6.2.6 Others had noticed changes which concerned them

"*A Home is only as good as it's staff, staff were younger and not worldly wise. They could have had training"*.

Money had been a concern over the years. Three families had given money for their person to have more opportunities as the weekly "allowance" was so small,

"*Over the years he contributed a monthly sum and was given a large amount of money back when she left the Home, none of it was spent on her".*

Two families talked about having to buy the person a bed, which was not returned to them when they left.

Mr Timms' family was extremely concerned about his treatment. His brother reported his concerns to the local authority, who in turn notified CQC. The staff and premises were dirty, and both Mr Timms and his room were not clean. Mr Timms brother had bought clothes for him, but found him wearing other people's clothes, on one occasion a woman's top. Getting the top on would have been painful for Mr Timms who could not lift his arms without pain. Mr Timms behaviour had changed a great deal, he had always been loudly spoken but was now mumbling, he said he was in pain. He had been moved from one house to another without his brother knowing, he had been in a ground floor room with easy access to a toilet which helped him manage a medical condition. In the new house he was in an upstairs room which different residents and a shared toilet. He begun to have falls. The carpets were threadbare which posed a trip risk. Mr Timms had two falls recently, his brother was not told until the following day, as a result of the fall Mr Timms had a broken cheek bone, was 'black and blue', had bruising to the chest and leg. Mr Timm's keyworker was great and demonstrated a lot of affection for him, but other staff were not so kind, and his brother heard very concerning stories after the Homes closed about the conduct of some staff

members. Some of the staff members were very young, 18 years old and left alone to care for the people living in the house, one had only been working there for two weeks.

Mr Timms brother was very aware that no external agencies had visited Mr Timms for some years. He was doing a great deal to try to support him, and like other families had bought him a bed and given him money. Mr Timms was a gregarious person who could seem alarming but had a warm heart, loving to see the children in his family. He was changing, and his brother was very concerned for him.

Cleanliness was noticed by other families, "*I didn't like the way they moved from changing a pad to cooking tea, it didn't feel right," "there was dog poo outside the kitchen and no one picked it up"* but generally this was forgiven in the light of positive and /or historical relationships with staff.

6.2.7 Analysis – Families

Any relationship between social workers from the placing authorities and the families of people in Nightingale had disappeared as working practices in local authorities changed. The strongest relationship families had was with Nightingale, if they had concerns they would speak with Nightingale staff. Some were responsive, some not, but families did not have trusted relationships with any other professional. Like their relatives, they had few benchmarks to compare care with, and some were also be afraid of the "consequences" to their family member should they speak out.

Now that families have also experienced a different form of care their perceptions have changed about what good care might look like. However, they also mourned the loss of warm relationships with Nightingale carers built up over the years.

The lack of involvement for some families in the persons move to other accommodation, coupled with the lack of involvement in reviews, has create a gap of mistrust that may never be bridged. Families can no longer feel they are working in a partnership with placing authorities. All the family members spoken with had worked extremely hard to make sure their family member had the best experience possible. With limited information and contact with the other agencies supporting the person they were often left unaware of where their best efforts can be placed. Their narratives express shock, guilt about not seeing what "the authorities" did, disbelief and anger that these events could happen, and grief at the loss of what they saw as a positive and well-known home for their relative.

6.3 Findings – the people and their families

6.3.1 Absence of relationship is a key theme throughout the accounts given by the people and their families. If either had concerns about the agency, i.e. the Provider with whom they had the strongest relationship, they had no alternative agency to discuss their worries with. When people did raise concerns, they were ignored by professionals, this would have

fed into the sense of helplessness and isolation experienced by the people living in Nightingale Homes.

6.3.2 The absence of dialogue and information also meant that there was no possibility of either families or people to be able to judge or rate their experiences. What can people expect from care services? What does good feel like? What should be expected, and what is definitely not good practice. We must think about how this can be achieved.

6.3.3 Nightingale had a strong culture of compliance, of people not challenging or complaining. If we wish providers to create cultures of openness, of acceptance of feedback and inclusion of people and their family representatives, we also need to look at how people and their families are included in the activities of commissioners and placing authorities, of how we can create an informed and supportive network around the person by working respectfully together to achieve well known and discussed aims.

7. Recommendations for South Gloucestershire Safeguarding Adults Board

The Review has identified a number of key concerns which can be addressed locally by the South Gloucestershire Safeguarding Adults Board and its' Partner agencies. It is important to share the Learning, Recommendations, Plans and other actions generated by this Review regionally and nationally, this will help to ensure that changes in practice are made regarding any Adult at Risk placed in the South Gloucestershire area and will enable the Safeguarding Adults Boards in the areas considered within this review to seek their own assurances regarding the practices described here.

7.1 SGSAB is recommended to commission the production of a Guide for professionals, adults and their families or representatives on standards, i.e. "what to expect" from a good care home. The guide must be accessible and contain clear information on what to do if expectations are not being met. The Guide must be person focused, using the standpoint of the person living in the service, i.e. would I want to live here?

SGSAB can learn from the experience of Torbay SAB who have produced a Guide in response to the Western Rise SCR (2016) Recommendation 10 "*Clear and simple standards about how a care home should look, feel and smell, should be produced, so that visiting staff, residents and families know what to expect. This should be supported by the development of harmonised quality assurance tools for the different professionals who carry out reviews in care homes*".

It is understood that the Guide is now complete, SGSAB is recommended to review this guidance for adaptation and use in the local area. Additions will need to be considered in the light of the learning from this Review, for example, in the Nightingale Homes people and their relatives did not understand how their money should be managed.

7.2 SGSAB is recommended to assure itself that all Partner agencies are aware of how and when to contact local adult safeguarding services, including the current Deprivation of Liberty Service. This will involve:

7.2.1 Clarifying what is adult safeguarding, and what is poor practice or a “quality” concern.

7.2.2 Specifying the routes for concerns and the expectations of reporting on all agencies, including those who place in the local area.

7.2.3 All agencies having full involvement in expressing concerns and contributing information regarding concerns. Agencies must be told what the response to their concern is, and if there is no response they must be aware of how to escalate concerns that they believe need an adult safeguarding or quality response.

7.3 The SGSAB will need to be assured that agencies have undertaken recommendations below.

SGSAB will also wish to make arrangements to share the learning and Recommendations of this SAR with the other SABs in the Placing Authority areas considered within this Review,

these SABs will also need to be assured that their own commissioners have acted upon these Recommendations.

8. Individual Agency Recommendations:

8.1 South Gloucestershire Council are recommended to work with the local Clinical Commissioning Group to produce a set of standards for commissioners placing in the South Gloucestershire Area. As South Gloucestershire Commissioners both may wish to consult with their equivalents in other local authorities who have placed in the Nightingale Homes. These standards will include:

8.1.1 The expectation that placing authorities will adhere to the legal duties under the Care Act 2014 with regard to planned, responsive and multi agency reviews; and adhere to the agreed (ADASS) protocols regarding informing the host authority of placements made in its’ area.

8.1.2 South Gloucestershire Council must develop a mechanism with which to capture information about the people placed in its’ area and consider how this information can be useful. For example, a commissioner who has place a number of people can be asked to undertake quality assurance activities and report back to the host authority.

8.1.3 People who are assessed as having complex needs which require the support of several agencies, or who have been placed in the knowledge that the placement has not been the most suitable, should be highlighted to the host authority. The host authority will need to be told what arrangements have been made to support the person in the placement and to ensure that the suitability of the placement is regularly ascertained. A named contact in the placing authority should be required. Placing authorities must be required to do this, but if necessary the provider can also inform the local authority.

8.2 South Gloucestershire standards for commissioners must also specify the expectations of placing authorities during and after any section 42 Enquiry, these expectations will be as required by the ADASS Out of Area Adult Safeguarding arrangements (2016). The standards

will also include the contact details of Adult Safeguarding and DoLS teams, including the leads for these services.

8.3 South Gloucestershire commissioners must set out their plans for assessing the quality of provision in the local area. These can also detail under what circumstances a placing authority will be asked to undertake a quality assurance exercise and how this will be reported back to South Gloucestershire commissioners.

8.4 It is understood by the lead reviewer that there is a regional project underway to create a Regional Framework for Adults with Learning Difficulty residential care placements. Outcomes include accreditation standards and improved quality assurance processes for these types of placement. This project may well assist with the implementation of the recommendations above, and will hopefully consider the learning from this Review, but learning and action must also extend to people with mental health issues and no learning disability, people who were also placed at Nightingale.

Commissioners and Providers

8.5 South Gloucestershire Commissioners and Providers are recommended to develop a strategy to promote cultures which welcome and respond to complaints within provided services. Being able to assert an opinion about a service, and have this responded to proportionately and calmly, can be a useful mechanism with which to empower the people who use services to influence those services, and to begin to understand how to protect their own rights whilst doing so. Some providers in South Gloucestershire are already taking this approach and can usefully inform this work.

All Commissioning (Placing) authorities, including the Host authority

8.6 Placing authorities considered within this review are recommended:

8.6.1 To review their systems for planned reviews. Are review dates tracked and known, can people who have had no review for more than two years be identified? What action will be taken regarding those who have not had a planned review for over two years?

8.6.2 To review mechanisms to ensure that families and representatives know how to express concerns and opinion regarding providers, and are, if the person consents, regularly invited to Reviews as a matter of course.

8.6.3 To review how placing authorities can maintain a consistency of relationship with those placed and their formal and informal networks. There must be an expectation that there is a multi-agency contribution to reviews when other agencies are working with the person, and that families or other involved representatives are invited to reviews as the person wishes.

South Gloucestershire Council

8.7 Adult Safeguarding Services are recommended to develop a tool with which to systematically evaluate indicators of potential organisational abuse. This will ensure a timely

and focused response to disparate reports which may be difficult to evaluate without a rigorous and well understood framework.

8.8 South Gloucestershire Council will also wish to take the lead on ensuring that the SGSAB is assured of recommendation 7.2 above.

8.9 **All agencies involved in supporting people to move from the Nightingale Care Homes** are recommended to reflect on the responses from the people and families involved in the transition arrangements; and share their response to this learning. It is recommended that the systems around a person must be understood, and those which will support them identified and utilised, before, during and for some months after any transition from one placement to another, particularly when the person has lived within a service for many years.

9 Glossary of Acronyms used in this Report.

ADASS – The Association of Directors of Adult Social Services

AMHP – an Approved Mental Health Act Professional

AWP- Avon and Wiltshire Mental Partnership Health Trust

BIA – Best Interest Assessor

BRISDOC – Bristol Doctors (currently out of hours service provider)

CLDT – Community Learning Difficulties team

CPA- Care Programme Approach

CPN – Community Psychiatric Nurse

CQC – Care Quality Commission

DNAR – Do Not Attempt Resuscitation

DoLS – Deprivation of Liberty Safeguards

ECG – Electro Cardio Gram

ED – Emergency Department (also known as Accident and Emergency)

GP – General Practitioner (a doctor)

ICU – Intensive Care Unit

IMCA – Independent Mental Capacity Act Advocate

LA – Local Authority

MCA – the Mental Capacity Act 2005

NBT – North Bristol NHS Trust

NHS – National Health Service

PCLS – Primary Care Liaison Service (mental health service point of entry for GPs)

PRN – abbreviation for pro re nata, Latin for “as needed”

SAB – Safeguarding Adults Board

SGSAB – South Gloucestershire Safeguarding Adults Board

Section 42 Enquiry – an enquiry carried out under section 42 of the Care Act 2014

Section 75 Agreement – an agreement between a local authority and the NHS

SWASFT – South West Ambulance NHS Foundation Trust

TIA - Transient Ischaemic Attack, a type pf “stroke” where effects last for a short amount of time.

10 References

- Association of Directors of Adult Social Services (2010) Protocols on Ordinary Residence
- Association of Directors of Adult Social Services (2016) Out of Area Adult Safeguarding Arrangements
- Care Act Statutory Guidance 2015 and updates 2016; 2017 and 2018

https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

- Marsland, D, Oakes, P White, C (2012) *Early Indicators of Concern in Residential Support Services for People with Learning D*isabilities: Centre for Applied Research and Evaluation, Hull University
- NHS and Community Care Act 1990
- Inspections of Nightingale Care Homes (various) Care Quality Commission

www.cqc.org.uk

- Torbay Safeguarding Adults Board: SCR concerning Western Rise Residential Home March 2016

https://www.torbayandsouthdevon.nhs.uk/uploads/serious-case-review-concerning-western-rise-residential-home.pdf