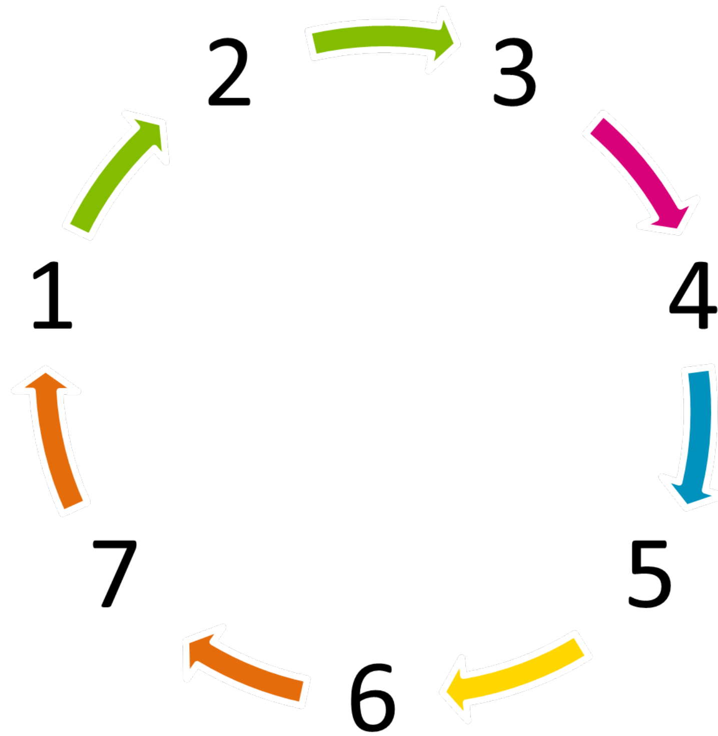

7 Minute Briefing: Helen

Safeguarding Adult Review (SAR): Helen

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Methodology

The Adult's Independent Chair is consulted on the methodology utilised in any given SAR, and mandates the approach.

The WSAB used a 'Systems Learning' approach in the review of Helen. This is a model that was introduced by the Social Care Institute for Excellence following the Munro Review of Child Protection published in 2011. This approach sets out to study the whole system and look closely at what influenced professional practice. It does this by taking account of the many factors that interact and influence individual worker's practice in a more in depth way. The process seeks to be a collaborative process with professionals being actively involved in the review from the outset. The approach promotes reflective thinking as a system to identify the causal factors that influenced practice for which improvements can be made upon.

Background

Helen was an elderly lady residing in a care home. Helen was found to have died following being trapped in the telescopic bed rails that were fitted to her bed. The bed rails had not been fitted correctly. A police investigation was completed; however the CPS made the decision that no criminal prosecutions were being pursued.

The main themes within the case are:

- Neglect and Acts of Omission
- Organisational Abuse

The main learning themes from the review are captured within Key Lines of Enquiry and in this case include:

1. Communication lines with the family
2. Use of telescopic rails and related risk assessment and safety monitoring
3. DoLs for restrictive measures in care plans
4. Organisational Culture

Learning points were identified through the case review, highlighting areas of learning and improvement.

1. Communication Lines with the Family

- **Considerations to the sensitivity of communication with the family are required**: The family were informed that Helen had passed away in her sleep, however on attending the care home they were presented with a crime scene. There was a long criminal and coronial process which culminated in the coroners office, without prior warning or communication as to the process, asking the family what they would like to do with Helen's "remains" and if they wanted to donate them to medical science.

- **Providing updates at regular periods, even if there is nothing to update on would be welcomed from the family**: The case was with NPS for an extended period of time and the family were without contact for extended periods as a result. Individualised communication needs should be explored.

- **Providing process overview and inter-dependencies, and consideration to advocacy or key worker representatives for the family would give them clarity and support during complicated parallel processes**: it was identified that utilising the Section 42 process regarding this matter would provide consistency in liaising with families.

- The care home summary of their internal investigation regarding the fitting (incorrectly) of the telescopic bed rails highlighted disparity between the quality markers associated with the care home against the CQC rating of the home, which was 'Good'; **Families of residents in care homes should be made aware of how they can access information relating to CQC inspection timeframes for a setting, as well as the quality markers ratings so that they can have informed dialogue with the care home regarding care expectations.**

Making a difference:

> Section 42 investigation processes have been amended to identify an appropriate (best placed) link person in cases with complex parallel processes, with systems guidance to capture this within S.42 Action Plans

> Development of a guidance tool for families selecting care homes based on what services providers are able to provide to check against an individual's needs and wishes in addition to the CQC inspection ratings

2. Use of Telescopic Bed Rails

- The Care Home's own investigation into the bed rail highlighted a lack of due diligence, including failure to undertake a risk assessment, and that the fitting by a senior care assistant was outside of home policies.

- **It was identified that the key learning regarding the use of telescopic bed rails should be highlighted both regionally and nationally**: current HSE advice available nationally still identifies these type of bed rails as appropriate. Wigan do not support the use of telescopic bedrails in their care homes.

Making a Difference:

> Immediate action was taken by the Provider Management and Market Development Team with all Care Homes in the borough to ensure that any users of telescopic bed rails had a robust risk assessment and were supported to decommission the use of these rails in the homes

> Further training and support via a toolkit for care homes regarding assessment, best interests/ DoLs (where appropriate), monitoring and quality assurance in relation to the use of all bed rails, which will be supported through the QPO role and via the Care Home Forum

> The concerns regarding the use of telescopic bed rails has been highlighted via the Independent Chairs Escalation Process to ensure national leads from government / wider agencies address any updates to national guidance and advice regarding this issue

3. DoLs for Restrictive Measures in Care Plans

- It was established that there was a lack of DOLS at the time of the incident, highlighting the need to **ensure all Care Homes have active systems to address where there is no DoLs in place regarding decisions involving key care interventions.**

Making a difference:

> PMMD to monitor Tier 2 referrals in relation to falls across care homes to support with least restrictive measures and cross reference with best interests/ DoLs authorisations

> Further training and support via a toolkit for assessment, best interests/ DoLs (where appropriate), monitoring and quality assurance in relation to the use of restrictive measures will be supported through the QPO role and via the Care Home Forum

> Development of a Training Competency Framework to support and monitor training activity in the delivery of MCA training across partner agencies

4. Organisational Culture

- The Care Home's own investigation into the bed rail further highlighted an inappropriate culture given the familial relationship of the senior care assistant to management leaving staff in fear of raising concerns.

Making a difference:

> Following the incident, the care home have undertaken internal actions in relation to fostering a transparent culture and providing new forums to raise concerns. This was identified as good practice and afforded the opportunity to share with other providers via the Care Home Forum alongside the production of supporting guidelines / toolkit

Practitioner questions to consider

1. **Has the family been informed of all processes and been kept updated, and has this been completed using trauma responsive practice?**
2. **Does the care provider have any apparent organisational issues (capacity, capability, culture) that could impact on service delivery?**
3. **Does the organisation have a transparent culture that allows staff to feel comfortable in raising concerns i.e. a Whistleblowing Policy?**
4. **Does the organisation have a good relationship with internal provider management teams that enables collaborative working in learning and development?**

Want to learn more?

Bed Rail Training:

[Training delivered by Provider Servicing Team to Wigan Care Home Forum]

Organisational Culture Change:

[Presentation to Wigan Care Home Forum]

Bed Rail Toolkit:

[In development by Wigan Council PMMD Team]

Parallel Processes Map:

[In development by WSAB]

WSAB Training:

WSAB Training Brochure 2021 (wigan.gov.uk)