

# Lessons Learnt Themes from Chronologies Relating to Alexander Court

1. **Overview**

This report was commissioned following a long involvement by partner agencies with the Alexander Court Care Home. The conclusions and recommendations are designed to assist at an organisational and individual level in any future similar circumstances. Chronologies were prepared from individual agency records.

The home had been the subject of concerns for a number of years and was well known to the agencies. It had been the subject of quality, safeguarding and regulatory intervention.

Joint decisions were taken to move residents from the home in conjunction with allied regulatory actions and the home eventually closed.

The chronologies used to provide evidence for the report mirror national and local examples of care provision where some improvements are achieved but not sustained. This makes the decision making and risk assessment of partner agencies crucial.

The report identifies areas of good practice but also makes recommendations as to how improvements can be made to take account of lessons learnt.

# Agencies Involved

* + Health and Adult Services, North Yorkshire County Council (HAS)
  + Care Quality Commission (CQC)
  + Medicines Management Unit
  + Partnership Commissioning Unit (PCU) acting on behalf of CCGs
  + Clinical Commissioning Group (CCG)
  + Continuing Healthcare (CHC)
  + North Yorkshire Police (NYP)

# Purpose of the Lessons Learnt Exercise

The purpose of having a Lessons Learnt exercise was not to reinvestigate or to apportion blame. The exercise was not an enquiry into matters that could be dealt with by coroners or criminal courts. It was:

* + To identify any lessons that can be learned from the case about the way in which local professionals and agencies work together to safeguard adults
  + To inform and improve local multi-agency practice
  + To improve practice by acting on learning (developing best practice)
  + To prepare and commission this overview report.

# Introduction

HAS identified the need to learn lessons from the case and partner agencies supported this approach. Although not introduced until April 2015 (after the home had closed) within the provisions of the Care Act 2014 the Local Authority has a responsibility for market shaping and commissioning of adult social care including managing provider failure and other service interruption. Within these responsibilities the local authority must ensure that the services being delivered are of good quality and promote the safeguarding and wellbeing of the people using them. When these events were taking place HAS had safeguarding responsibility for everyone living in the home but was only responsible for the care arrangements of those funded by the council. However HAS along with partners took the conscious decision to offer support to all people living in the home including those that funded their own care.

The report considers the recurring themes highlighted in the chronologies covering the period 18 December 2013 to 17 December 2014 from the agencies involved and investigates where changes could have been made earlier in the intervention with AC.

The approach taken to research this report was to consider all chronologies relating to AC covering the period and to pick out any information that may have suggested good and alternative practice.

In the context of the events which took place and any subsequent decision making the report considers what went well, what didn’t go well and importantly what has so far been put in place as lessons have been learnt.

Further recommendations are also made as a result of the findings of this report.

# Agency Interventions

Esteem Care purchased the Alexander Court (AC) Home, formerly known as Waldenheath Care Centre in March 2010. On the 7th July 2010 a joint visit was undertaken by Adult and Community Services (now Health & Adult Services) and CQC. This was prompted by concerns that the home was not meeting the quality standards required by HAS and CQC. Action was taken to ensure the service improved and improvements in the service were evidenced. This was in the form of action plans that were monitored by the respective agencies

On 26th June 2011 the home then extended their registration with CQC to include nursing care.

On 18th February 2013 the agencies listed above became involved with AC again and for a period of 18 months monitored concerns relating to the care delivered within the home. The chronologies highlight the interventions and the joint meetings that were held during this period of monitoring.

As a result of the death of a resident there was involvement of both the police and coroners court. No prosecution arose from the police investigation and the death was the subject of an inquest.

Key features include the holding of regular “strategy” meetings and on-going support and monitoring of the home.

However there are indications that the role of the organisations and their powers to act were not fully understood. The extent of the failings of the home’s management only became apparent during this period of scrutiny.

The chronologies identified the following specifically:

* + A corroboration of recording across agencies that identified key events and actions taken
  + Regular unannounced monitoring visits
  + Improvements were evidenced in terms of training & medication but these were not maintained
  + Good communication between staff at operational level
  + Some confusion over the actions that agencies could take i.e. CQC regulatory powers, Commissioners contractual powers & Police powers
  + There was systematic failure in the home management which the support from agencies masked to some extent
  + In the urgency of the situation communication with relatives and staff was initially ad hoc

# Care Home Management

A key feature of the home was the extent to which poor management lay behind the problems. This is mirrored in similar situations both nationally and locally. Given the emphasis put on leadership in the care sector it is a key question in this and future scenarios as to whether this could have been identified earlier.

Contributing factors were:

* + Co-operation in respect of sharing staff rotas with commissioners was evident but in other areas there was little co-operation
  + Only some staff training issues were addressed by the management
  + Any material changes were not always reflected in residents’ care plans
  + Communication between the home manager and the company directors did not reflect the position within the home.
  + Managers did not always attend key meetings
  + Poor communication between the home manager and owners

# Closure Process

Actions were taken to influence improvements. When this seen to be unsuccessful those agencies with commissioning responsibilities made the proposal to cease commissioning with the home and this was agreed on the 21st July 2014. In the same period CQC were following their compliance process and took the decision to remove AC’s nursing registration. These

decisions were due to the home failing to improve standards, it was felt the residents of AC were at risk of not staying safe and plans were put in place to move residents to alternative placements.

It was following these decisions that the provider notified commissioners that they had decided to close the home. The last resident left AC on the 21st October 2014.

The decision to close/move residents was a complex one and demonstrates how confusion over responsibilities arose. At the point where moving residents was deemed to be needed there was close liaison between CQC and commissioners. The action CQC took gave commissioners time to plan the process but therefore was not an immediate closure. The decision by the home owners then precipitated this.

Clearly the actions of the agencies had in mind the impact a move would have on residents. If the extent of the management failings had been known earlier the closure may have been brought forward and could have been assisted by a review preferably by managers not directly involved.

Key aspects of the closure process were:

* + Agencies focus was on the wellbeing of residents through supported improvement of the service
  + Concern over the impact of moving residents played a part in timescales and decision making
  + Agencies worked to co-ordinate closing arrangements once the decision had been made but the owners’ action brought this forward
  + The practical arrangements for moving residents to alternative accommodation, including communication and moving of belongings, could have been better
  + Mobilisation of staff to assist with the moves was good and this included helping self- funding residents

# Post Closure

A number of actions were taken following closure including the commissioning of this report. Allied to that some changes are or have already been implemented. Very usefully a study was undertaken to ascertain the impact of the closure and move on residents.

* + 71% of residents were found to be happier after the move. 23% had died within 6 months of the move but this is considerably lower than is often assumed.
  + The above figures should challenge views regarding the dangers that moving people may cause
  + There is evidence that alterations to process have already had an impact in similar situations where actions have been jointly taken to move residents

# Recommendations

On the basis of the chronologies the following is recommended:

1. Agencies (HAS & CCGs) to review their monitoring and quality assurance processes to:-
   1. Ensure a range of consistent tools are used to examine the care and leadership within a home
   2. Ensure escalation processes for decision making are in place including with other agencies
   3. Review to ensure clear guidance for decommissioning due to poor quality
   4. Review the process for the practical arrangements for moving residents
2. Agencies (HAS, CCGs, CQC & NYP) involved in Safeguarding & monitoring to jointly:-
   1. Develop risk profiles that pro-actively identify indicators of poor quality
   2. Ensure that where there are long standing concerns about a provider’s quality a review is undertaken independently to support and/or challenge decision making
3. Agree communication procedures for residents, relatives & staff
4. Agencies (HAS & CCGs) to ensure communication is directed to the correct level within the provider organisation
5. Use an extended countywide “Engagement Meeting” and local Safeguarding Groups (LSAGs) to consider the report and any outstanding issues over agency roles and responsibilities
6. Report to be shared with the provider and other Local Authorities, Clinical Commissioning Groups and Safeguarding Adult Boards where they have care homes
7. Report to be considered by Safeguarding Adults Board (SAB) and senior managers of partner agencies. SAB should monitor compliance and report on progress in its annual report.