The Regulation and Quality Improvement Authority

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Independent Review of the Western Health and Social Care Trust Safeguarding Arrangements for Ralphs Close Residential Care Home

August 2012

informing and improving health and social care
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The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews are designed to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. Our reviews are carried out by teams of independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health, Social Services and Public Safety, and are available on the RQIA website at www.rqia.org.uk.

In addition, when required, we carry out reviews and investigations in response to specific issues of concern or failures in service provision.

This review has been instigated following anonymous allegations of abuse of vulnerable adults in Ralphs Close Residential Care Home, Londonderry.

This review has been undertaken under article 35(1) (b) of the 2003 Order.

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1. Introduction and Background to the Review

1.1 Introduction

Ralphs Close Residential Care Home provides accommodation and support for adults with a learning disability. The home is situated at the rear of the Gransha Hospital site and was constructed in 2010 by Trinity Housing Association.

The home provides single room accommodation for 16 adults and is divided into two separate, identical buildings, each containing two self-contained units for four residents. The home is managed by the Western Health and Social Care Trust (Western Trust) and the building is owned and maintained by Trinity Housing Association.

Most of the residents who live in Ralphs Close moved there from long-stay learning disability wards on the Gransha site. Several residents have also been receiving inpatient care on the site since childhood.

On 24 July 2012, an anonymous letter (undated) was received by the Western Trust in respect of allegations of physical and psychological abuse of vulnerable adults. The letter referred to Ralphs Close Residential Care Home.

On 25 July 2012, a copy of the letter was forwarded to RQIA in line with reporting procedures for notifiable events.

On 25 July 2012, in line with the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults[1], (Joint Protocol) the Western Trust convened a multi-agency strategy meeting to consider the allegations; to decide on the lead agency for the investigation and to develop an appropriate protection plan for service users. It was agreed that the Police Service of Northern Ireland (PSNI) would lead a single agency investigation into the allegations. It was also agreed that the Western Trust would initiate a protection plan in respect of residents living within the establishment. A further adult safeguarding meeting was held on 26 July 2012 at which the protection plan was reviewed. RQIA participated in both meetings by teleconference.

On 27 July 2012, the RQIA Chief Executive wrote to the Western Trust Chief Executive to seek assurance "as to the robustness of the protection plans that have been put in place by the trust in light of these serious allegations". The Western Trust Chief Executive replied on 31 July 2012, stating: "the trust has collaborated closely with RQIA and PSNI colleagues to ensure that these anonymous allegations receive thorough investigation, and is a paramount concern to the trust that the safety of residents in Ralphs Close is protected on an ongoing basis throughout the investigative process".

[1] Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (July 2009):

On 6 August 2012, RQIA carried out an unannounced inspection of Ralphs Close. In view of the findings of the inspection, RQIA determined that action should be taken in relation to non-compliance with a number of regulations. This was subsequently taken forward separately and is not the subject of this report.

Following this unannounced inspection, RQIA also determined that it should carry out a separate review of the safeguarding arrangements in place at Ralphs Close Residential Care Home. The RQIA Chief Executive wrote to the Western Trust Chief Executive on 8 August 2012 and stated: "RQIA intends to investigate the current safeguarding arrangements in place at Ralphs Close as part of the protection plan for vulnerable adults residing at that facility". The terms of reference for that investigation were enclosed as set out below.

The review was conducted in accordance with Article 35 (1) (b) of the Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003.

1.2 Terms of Reference

The terms of reference for the review were:

1. To review the management and practical arrangements, established by the Western Trust, for the safeguarding and protection of residents of Ralphs Close Residential Care Home during an investigation set up to consider allegations made in relation to care in the home.
2. To make recommendations for actions to be taken in relation to any issues which may be identified with the practical or governance arrangements which have been put in place.
3. To identify any learning from the circumstances and make recommendations to take this forward.

1.3 The Review Team

- Mrs Miriam Somerville, former Co-director of Learning Disability Services, Belfast HSC Trust
- Mr Philip O'Hara, Inspector, RQIA

The review team was supported by:

- Mrs Jacqueline Murphy, Senior Project Manager, RQIA

1.4 Methodology

1.4.1 Information Requests

RQIA wrote to the Western Trust to request its cooperation in informing the review. Detailed information was requested and received from the trust to include:

- A chronology of the events from the date the anonymous letter was received (24 July 2012), listing the actions taken by the Western Trust which are relevant to the review's terms of reference.
- Copies of all relevant minutes of meetings and correspondence with regard to the chronology of events.
- Organisational structure(s) in respect of the review, to include the trust, the Directorate of Adult Mental Health and Disability Services; and staff structures in Ralphs Close Residential Home.
- Western Trust protection plan.
- Individual protection plans for each client in Houses 3 and 4.
- List of independent senior staff (monitors) who were allocated on a twenty four hour a day seven day a week basis to ensure resident's safety in the home.
- All monitoring reports from senior independent staff (on a shift by shift basis).
- A description of the arrangements in place for monitoring, reporting and reviewing incidents and restrictive practices.
- Residents' communication arrangements in Ralphs Close Residential Home.
- Documentation relating to briefings and/or communications provided to staff, residents and families since 24 July 2012.
- Copies of all relevant policies and procedures.
- Copies of all relevant governance documentation (e.g.: incident reporting, risk registers, etc.) with regard to the chronology of events.
- Relevant training plans and all training undertaken by staff in Ralphs Close during the past year (i.e.: 24 July 2011 – 24 July 2012).

- Reports or reviews the trust has completed in respect of the home/homes under Regulation 17 Residential Care Homes Regulations 2005.

- Monthly monitoring reports in respect of the Homes under Regulation 29 (1) Residential Care Homes Regulations (Northern Ireland) 2005.

1.4.2 Interviews and Meetings

An orientation visit to Ralphs Close Residential Care Home was undertaken by the review team.

Interviews were held with Western Trust staff who have a responsibility for the oversight of management arrangements within the home, as well as general governance within the Western Trust.

The review team thanks the Western Trust for its co-operation throughout this review and, in particular, those staff who were interviewed.

2. Chronology of actions taken by the Western Trust following the receipt of an anonymous letter

DATE	EVENT
24 July 2012	• Anonymous letter received by Western Trust around 18.00 by Head of Service (HOS) relating to Ralphs Close.
25 July 2012	• **09:00**: Letter shared with key personnel within the trust and Director of Adult Mental Health and Disability Services informed. • **10:45:** Trust Adult Safeguarding Specialist contacted and agreed to convene urgent multi agency strategy meeting that afternoon. • **11:00**: Consultation with PSNI under Joint Protocol. • **11:15**: Employee relations informed regarding the anonymous letter. • **11:39**: RQIA informed and copy of allegation letter forwarded. RQIA invited to attend adult safeguarding meeting. • Trust acting Executive of Director of Social Care, Executive Director of Nursing and Chief Executive informed of letter. • **14:30**: Adult safeguarding strategy meeting held chaired by Western Trust Adult Safeguarding Specialist Manager. PSNI present at meeting. • RQIA represented by teleconference link. • **17:00**: PSNI and HOS carried out an unannounced visit to Ralphs Close to examine CCTV system. • **22:15**: HOS carried out a further unannounced visit to Ralphs Close. • On 25 July 2012 key workers and the Community Services Manager were briefed to inform families.
26 July 2012	• Lakeview Hospital Manager redeployed into independent monitoring role within Houses 3 and 4, Ralphs Close. • PSNI Officer and HOS met with Ralphs Close manager to explain that investigation was needed as trust were in receipt of an anonymous letter. Details of allegations were not disclosed. • Relevant files and documentation were secured by PSNI and HOS. • Staff on duty within Houses 3 and 4 briefed on anonymous letter received and PSNI-led investigation. • Staff not on duty advised by telephone that a briefing meeting would take place on Friday 27 July 2012. • Adult safeguarding update meeting held at 14:30. • Community Care Manager commenced visits to families of those named in allegation letter to inform them of this. • Updates provided to all professionals notified on 25 July 2012.

27 July 2012	• Briefing meeting held by PSNI officer and HOS for staff within Houses 3 and 4, Ralphs Close. • Trinity Housing Association informed of situation and permission sought from them to remove CCTV hard drive. CCTV hard drive was removed and secured. • Independent monitoring extended to 24/7 to include night time cover. • Form 1a – Notification of Events forwarded to RQIA. • Early Alert Proforma issued to DHSSPSNI by Western Trust Head of Clinical Quality & Safety. • Learning disability consultant psychiatrist carried out an assessment of capacity on three residents named in the allegation letter. • Consultation with PSNI regarding investigation process. •
30 July 2012	• Request from PSNI for list of names and addresses of all staff working within Houses 3 and 4 in order to issue PSNI crime stoppers letter. • Request from HSC Board to share minutes of safeguarding meetings of 25 and 26 July 2012. •
31 July 2012	• PSNI commenced interviews with staff. Director and Royal College of Nursing trade union representative supported this process. • All secured files/documentation and CCTV hard drive transferred to PSNI care. • Residents' next of kin and contact details forwarded to PSNI on request.
1 August 2012	• Western Trust received correspondence from Public Health Agency (PHA) seeking clarification on the independent monitoring role. • Clarification and assurances provided to PHA by HOS. • Request from PSNI for names and contact numbers for staff within Ralphs Close. • PSNI provided with contact details of staff working within all four houses within Ralphs Close.
2 August 2012	• Agreement on response to any media enquiries. • Communication received from team leader to confirm families had no further concerns. • RQIA representative briefed by Adult Safeguarding Specialist on the progress to date.

3 August 2012	• Adult safeguarding case discussion • Community team leader updated families of PSNI involvement in investigation.
6 August 2012	• Unannounced inspection of Ralphs Close by RQIA.
7 August 2012	• Communication with families in Houses 1 and 2 commenced. • Interim manager placed in Ralphs Close to cover the manager's planned annual leave. • Meeting took place with trade unions and community learning disability nurses regarding staff cover for the rota of monitors. • Trust Assistant Director and HOS visited Ralphs' Close to talk to staff within Houses 3 and 4 to update them on the protection plan and the arrangements for independent monitors. • Feedback on unannounced inspection of 6 August 2012 sought from RQIA. Feedback indicated that RQIA intended to issue Failure to Comply notices with regard to three regulations, with correspondence confirming this to follow. This information was escalated to the Director for Adult Mental Health and Learning Disability. • Team leader also forwarded information to Adult Safeguarding Specialist regarding a complaint from a family member. This was shared with PSNI.
8 August 2012	• Letter from RQIA Chief Executive to Western Trust Chief Executive stating the Terms of Reference of a review of governance arrangements in relation to the protection plan. • Press release agreed and issued by the trust's communication department. PSNI advised.
9 August 2012	• Trust representatives attended a meeting at RQIA regarding regulation issues and RQIA intention to issue 3 Failure to Comply notices. • Second meeting held at RQIA regarding intention to carry out a review. • Acting Executive Director Social Work and Executive Director of Nursing at the HSC Board updated. • Media brief released. • Ralphs Close manager commenced annual leave and temporary manager in place until their return.

10 August 2012	• Arrangement made to convene a Joint Protocol meeting on 15 August 2012. • Update from PSNI to Adult Safeguarding Specialist. PSNI investigation progressing. PSNI confirms it does not intend to progress the investigation to Houses 1 and 2. • Consideration of the non-compliance letter from RQIA revisited and steps taken to address the areas listed in the letter and the prioritisation of actions by deadline set in letter. • Independent monitoring role documented and issued to monitors with reporting proforma. • Written brief on monitors' role and function provided to staff within Ralphs Close.
13 August 2012	• Briefing provided to independent monitors on their role and function.
14 August 2012	• Further briefing sessions provided to independent monitors. • Anonymous telephone call received by RQIA duty inspector outlining further concerns regarding historical alleged abuse and the investigation that was conducted at that time. • Western Trust made aware of this by RQIA.
15 August 2012	• Meeting of trust senior managers held to agree next steps in relation to further anonymous information disclosed. • Multi agency case discussion with PSNI and RQIA held in afternoon to receive an update on the current PSNI investigation and to review the protection plan. This meeting also discussed the new allegation received by RQIA.
17 August 2012	• Trust staff interviewed by RQIA review team.
22 August 2012	• Orientation visit to Ralphs Close by RQIA review team. • Further interview with staff held by RQIA review team.

3. Response by the Western Trust to the Allegations

3.1 Introduction

The review team considered documentation provided by the Western Trust, and information gained through interviews with trust staff, in relation to the trust's response to the receipt of an anonymous letter with allegations that abuse had taken place at Ralphs Close Residential Care Home.

The review team identified five areas for review in this regard:

- the immediate response to the receipt of the anonymous allegations
- decision making as to whether any staff should be subject to precautionary suspension
- the role of independent monitors within Ralphs Close
- communication within the Western Trust about the incident
- communication with other relevant authorities

3.2 Immediate Response to the Receipt of the Anonymous Allegations

The review team noted that the Western Trust had taken action immediately following the receipt of the letter on 24 July 2012.

A strategy meeting with all relevant parties was convened for the following day. In line with the Protocol of Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults, PSNI and RQIA were informed about the allegations and invited to the strategy meeting.

The minutes of the meeting record that there was discussion on:

- safeguarding concerns related to the allegations made in the letter
- leadership for an investigation of the allegations, with PSNI agreed as the lead agency to carry out a single agency investigation
- securing documentation and possible CCTV footage
- capacity assessment of residents to participate in the investigation
- possible identification of the individual who wrote the letter
- communication with staff and relatives
- development of an immediate protection plan

At that meeting, it was agreed that a monitoring oversight would be provided by independent senior staff.

The review team concluded that the Western Trust responded appropriately on receipt of a letter containing serious allegations by convening a strategy meeting in line with agreed procedures.

At the strategy meeting on 25 July 2012 it was noted that there had been no incidents reported which had been investigated under the vulnerable adults

procedures. At the meeting on 3 August 2012, it was reported that there was "a previous unrelated anonymous allegation in Ralphs Close and also that there have been unrelated internal HR processes which have been applied".

Historical enquiries in learning disability services[2] [3] indicate that seemingly unrelated incidents can, over time, be seen to be part of a pattern of poor practice and sometimes of abuse.

LEARNING FOR THE FUTURE
All reports of previous allegations or disciplinary actions are considered in the early stages of the development of a safeguarding plan.

3.3 Decision making with Regard to Possible Precautionary Suspension of Staff

In developing a safeguarding plan, the Western Trust considered whether or not staff should be suspended on a precautionary basis. The minutes of the strategy meeting held on 25 July 2012 document the assessment of the level of risk which was carried out as follows:

1. There are no named perpetrators.
2. There have been no complaints in this regard from families.
3. There have been no issues in this regard highlighted through the regulatory processes.
4. There have been no other incidents reported which were investigated under the vulnerable adults procedures.
5. It was noted that the letter is anonymous and at this stage no part can be substantiated or verified in any way.
6. Giving due consideration to employment legislation and requirement in line with trust policy, the alleged group of staffs' human rights were considered under Article 6 of the European Convention on Human Rights. The good practice of staff within these units was also acknowledged, and it was accepted that these positive relationships with the residents should be maintained within a safe environment where possible.

Outcome: For the above reasons it was agreed that precautionary suspension of 17 staff would not be a proportionate response.

During interviews with trust staff, the RQIA review team discussed decision making in regard to the possible staff suspensions. Staff advised that the decision not to suspend was reached after careful consideration of the issues.

[2] Joint investigation into the provision of services for people with learning disabilities at Cornwall Partnership NHS Trust: Healthcare Commission (July 2006)
[3] Investigation into the service provided for people with learning disabilities provided by Sutton and Merton Primary Care Trust. Healthcare Commission (January 2007)

Suspending all staff would have meant the closure of the home. Finding accommodation and appropriate support packages for individuals with such complex and challenging needs would have been extremely difficult. The impact on the residents, for whom consistency of staff is important, was a major factor in the decision making process.

As no individual staff members were identified in the letter, The Western Trust considered that it would have been necessary to suspend all day staff. The Western Trust believed that the disruption to the residents would be so detrimental that this action would have been disproportionate. The Western Trust therefore decided to provide a monitoring role using independent staff.

The RQIA review team has concluded that there was careful consideration of issues prior to the decision taken not to suspend staff on a precautionary basis. Nevertheless this decision did mean that there was the possibility that members of staff who had participated in alleged previous episodes of abuse would still be at work during the investigation.

The review team considers that it could have been possible through detailed examination of diary logs, incident reports and rotas, to identify members of staff who may have been on duty at the time when the alleged incidents could have occurred. This could have restricted the number of staff who would have been subject to the precautionary suspension as part of the interim protection plan.

A number of trust employees interviewed expressed the view that possible actions which could have been taken by the trust following the allegations were constrained by the primacy of the PSNI investigation. The review team did not find any evidence that this issue was raised at the strategy meetings, so that the potential for additional actions could have been clarified.

At interview, the review team was informed by trust staff that it has been possible to identify some staff who were on duty at the time of an incident when a resident sustained a fracture. The trust advised however that this had been considered at a strategy discussion. It was agreed the injury could possibly have taken place prior to the day it was observed, and might then have occurred during the day or night. For this reason the service division determined it was not possible to suspend the number of staff who may have had contact with the resident during the timeframe prior to the injury.

In light of the allegations and this further information, the review team believes that, without a satisfactory explanation of the fracture, it could be argued that these staff may pose a risk to residents. The review team considers that decisions as to precautionary suspension should be kept under continuous review as new evidence emerges.

RECOMMENDATION

1. The Western Trust should keep decisions regarding the precautionary suspension of staff under continuous review throughout an investigation as new evidence emerges.

3.4 The role of independent monitors

At the initial strategy meeting of 25 July 2012, it was considered that a registered nurse with appropriate "experience, competence and confidence to report any concerns or incidents" would reduce the risk of alleged abuse reoccurring. It was agreed that, from 26 July 2012, a staff nurse would commence supervision and observation of day staff on an 8am to 8pm basis, 7 days a week. This decision was reviewed at an update meeting held on 26 July 2012, when it was agreed that additional staff members, from outside the staff group of Ralphs Close, would provide this monitoring role. It was agreed that staff carrying out the role should be professionally qualified nurses or social workers. The trust Chief Executive advised the RQIA Chief Executive by letter dated 31 July 2012 that the monitoring role was then being carried out on a 24 hour basis 7 days a week.

The RQIA review team met two members of staff carrying out the monitoring role at Ralphs Close.

One of the monitors reported that they were phoned at home on the evening of 25 July 2012 and asked by the Head of Service to meet first thing the next morning. On the morning of 26 July 2012, the monitor was introduced to the home and staff were informed of their role.

This particular monitor, a nurse by profession, stated that they initially had had some difficulty in understanding the monitoring role. The monitor told the review team that their role was now clear and had been set out in a written brief provided on 10 August 2012. The monitor also spoke positively about a recent meeting within the trust which had been held "to sort out a number of everyday issues" relating to the monitoring role.

LEARNING FOR THE FUTURE

The development of a written brief for independent monitors and a reporting template is important. Introducing these to monitors as early as possible should help to make the role clear and understandable, both to them and to other staff.

It is important that the trust continues to meet regularly with monitors to answer operational questions which arise during an investigation.

The review team recognises that establishing an appropriate team of independent monitors at short notice during a vulnerable adult investigation is challenging. Nevertheless, the review team concluded that the monitors put in

place during this investigation could be viewed as not being sufficiently independent. Although these monitors work in different areas of the service, many of them had previously worked with the current staff in Ralphs Close and with the residents. Seeking assistance from other HSC trusts or voluntary sector organisations could have helped in achieving greater independence for the monitoring role. It would be useful for this possible approach to be discussed at regional safeguarding forums.

The review team questioned whether one monitor could provide sufficient oversight in two houses. The review team believed that in addition to the monitors, consideration could have been given to supplementing existing staffing on each shift with one or two experienced residential care/support workers from elsewhere. These staff would not have a monitoring role but could demonstrate examples of good practice in residential care, as they work alongside the staff team. The review team recognised that there are no other trust residential learning disability services in the immediate geographical area but partnerships with local voluntary or private sector providers may be of assistance.

From the information provided, the review team also noted that all the monitors were nurses, although the initial decision had been to include social workers on the rota. The trust has advised that the decision that the monitors should be registered nurses, was taken following advice from the PHA. Subsequent advice to the trust, from HSCB/PHA, has been that the monitoring role can be extended to include social work professionals of the same seniority and competence as the nursing staff fulfilling this role.

Ralphs Close is a residential care establishment and, as such, provides social care and support for the residents. Oversight by both nurses and social workers would bring both independence and a multidisciplinary view regarding ongoing care practice.

The number of staff working in disability services in Northern Ireland is small. This creates a significant challenge when a safeguarding plan has to be developed that necessitates finding additional staff. The trust may wish to consider collaborative working with learning disability services in other trusts and/or with voluntary sector providers to support each other when such need arises. Experienced and skilled staff from residential services elsewhere would have assisted Ralphs Close in bringing independent expertise, and assurances that the needs of the residents would be appropriately met.

RECOMMENDATION

2. The Western Trust should review the monitoring arrangements at Ralphs Close to ensure that the monitors are independent of the staff working there.

3. The Western Trust should examine the potential for collaborative arrangements with learning disability services in other trusts and/or voluntary sector providers to assist with the provision of skilled and independent staff in times of crisis.

3.5 Communication within the Western Trust about the Incident

The review team considered the information provided by the Western Trust about the chronology of events and discussed communication with staff who were interviewed.

The review team has concluded that relevant managerial staff and directors were promptly informed about the allegations made in the anonymous letter concerning Ralphs Close Residential Care Home and were actively involved in the follow up to the incident. A number of staff with managerial responsibility were on leave at times throughout the management of the incident, however deputising arrangements were in place.

Arrangements were put in place to inform staff at the home of the situation and also to inform the families of the residents in the home.

3.6 Communication with other relevant authorities about the incident

Following the receipt of the anonymous letter, the trust informed PSNI and RQIA in line with the requirements of the Joint Protocol. A strategy meeting was arranged for the following day and the relevant organisations were invited.

The trust reported the incident to:

- RQIA in relation to the statutory reporting of notifiable events
- DHSSPS as part of the Early Alert Reporting System
- the Acting Chief Nursing Officer DHSSPS and the Director of Nursing PHA
- the Regional Safeguarding Officer at HSCB

The RQIA review team has concluded that the incident was reported to the relevant organisations, and, from the evidence submitted, that the trust has cooperated with the follow up actions taken by these organisations.

4. Protection of Vulnerable Persons with Learning Disability

4.1 Context

Ralphs Close Residential Care Home provides a social/residential care home for 16 individuals who had previously been hospital patients in the Mourne House, part of Gransha Hospital. All staff interviewed praised Ralphs Close for the excellent physical environment it provided for the residents. In addition, staff also told the review team about the improvements noted in the residents since their move. This was reported to be particularly noticeable in the behaviour of residents who had presented significant challenges in the hospital environment.

Many of the staff working in Ralphs Close previously worked with the residents in Mourne House. This is helpful to residents for whom consistency and continuity of staffing is an important element in their life. There are, however, risks inherent in hospital staff being expected to switch to a social care living environment without the necessary experience and additional training.

Social care means different standards and a culture of supporting people to be as independent as possible rather than being cared for.

It is important that the governance arrangements provide for effective monitoring of the quality of service provided in Ralphs Close in terms of the following elements.

4.2 Incident Reporting

The review team was made aware of inconsistencies in the reporting of incidents and restrictive practices, and the likelihood of under reporting of both.

Difficulties with the reporting of incidents and restrictive practices were highlighted by several of those interviewed. If the safeguarding plan is to work successfully, these difficulties must be addressed. Incident reporting and learning from incidents are key quality indicators in learning disability services as are reporting, monitoring and reviewing of restrictive practices. Open discussion about incidents and restrictive practices can help staff to understand that neither are a “bad” thing and both are intrinsic parts of a learning disability service, particularly one that supports people with challenging behaviours. The important factor is that learning from both incidents and restrictive practices is used to continuously improve the lives of the people being supported.

The review team was advised that changes are currently underway within the Western Trust to ensure that all incidents are reported.

In the reports presented to the review team, it was noticeable that there were a significant number of unexplained injuries documented. Unexplained injuries are a common feature in congregated learning disability hospital wards. The review team considers however that in small, individualised settings such as Ralphs Close, unexplained injuries should be a rare event.

RECOMMENDATION

4. The Western Trust should put arrangements in place to ensure that staff and managers are aware of the requirement to report all incidents in Ralphs Close. Regular incident reports should be delivered to managers in a format that enables them to examine trends and discuss appropriate measures with the staff team.

The review team was informed of some difficulties with the introduction of a new Datix incident recording system. It is important that staff are fully trained in the new system as quickly as possible and that the system is utilised to produce meaningful reports as outlined above.

AREA OF GOOD PRACTICE

The reviewers were made aware of one head of service who has introduced a system of sharing incident reports with his team. This good practice should be rolled out across the service.

The manager at Ralphs Close is given sole responsibility for important decision making about closing incidents, taking further action and deciding what is discussed with the designated officer in terms of vulnerable adult procedures. It is important that the manager is properly supported in making these decisions and that a quality assurance mechanism is introduced to regularly check actions taken in incidents that are closed.

4.3 Restrictive Practices

In general, most staff act with the best of intentions in trying to protect an individual, however they may be unaware that their actions may be restrictive and could be considered as abusive. The review team was made aware of some instances of this happening despite the Western Trust's policy on restrictive practices. It is of particular importance that staff understand the implications of restrictions when they are working with people who have little verbal communication. Staff must remain aware that although individuals don't talk, this does not mean that they do not communicate. All staff must be well briefed on the variety of means that residents use to make their wishes known.

The review team was also made aware of the difficulties being experienced in providing training in restrictive practices to all Ralphs Close staff.

RECOMMENDATION

5. A system of regular reviewing of all restrictive practices in Ralphs Close should be developed by the Western Trust. This should result in a monitoring report being presented to the learning disability governance group at agreed intervals.

The Management of Aggression and Therapeutic Holding Skills (MATHS) is the programme used for training staff in physical interventions. There are many training tools available providing that the training is non pain compliant and advocates positive behavioural support; several are suitable.

It is considered best practice for physical intervention training in learning disability services to be accredited by the British Institute for Learning Disabilities (BILD). The review team was assured that the training is non pain compliant, however the trust may wish to check that their training is BILD accredited. The recent enquiry into services at Winterbourne View highlighted the importance of appropriate training and monitoring in physical intervention.[4]

The review team noted a number of concerning physical intervention techniques recorded in the incident reporting. For example one incident report states "the patient broke free from a constructive grip to aid in the shaving process". This perhaps raises questions about the culture within Ralphs Close. For instance, could staff have employed some techniques to calm the resident before shaving, could the resident have been shaved later when he was relaxed or in fact could the resident's desire not to be shaved have been respected?

The review team also noted several references in the MATHS training to violence. Individuals with learning disabilities who challenge services are often using behaviours to express something because they have no other means to do so. Staff who understand, respect and respond to this by developing engagement and interaction with the individual rather than control are more likely to be supporting that individual to lead a meaningful life.

Individuals with complex and challenging needs can be helped by using a range of person centred approaches such as intensive interaction and person-centred active support. This can also provide a more rewarding experience for staff who work with individuals who challenge or who have profound and multiple difficulties. The review team was made aware of excellent facilities in the Berryburn Centre, a day centre on the Gransha site that could be used constructively to promote better engagement and interaction.

Two reports by Professor Jim Mansell[5], may be of help in the consideration of more positive engagement with the residents.

[4] Report of the NHS Review of commissioning of care and treatment at Winterbourne View. NHS South of England. (August 2012)

[5] Services for People with Learning Disability and Challenging Behaviour and/or Mental Health Needs: Department of Health, Professor Jim Mansell (2007)

RECOMMENDATIONS

6. The Western Trust should ensure that all staff undertake appropriate training and refresher training in incident reporting, restrictive practices, vulnerable adults and physical intervention.

7. The Western Trust should ensure there are arrangements in place to provide management oversight, support and training to the manager in Ralphs Close in making important decisions about the reporting of incidents, vulnerable adult investigations and restrictive practices.

8. The Western Trust should consider how to improve engagement and interaction with the residents to lessen the need for restrictions and physical interventions.

4.4 Advocacy

It was reported to the review team that there are two advocates who visit facilities for adults with learning disability on the Gransha site, including Ralphs Close Residential Home.

These advocates include one parent of an adult with learning disability and a retired experienced nurse manager from learning disability. They do not have a formal contractual arrangement with the trust and their roles and responsibilities are not clearly defined.

Despite this, the advocates are listed as a component of the global protection plan as part of the trust's response to the allegations.

The review team was concerned about the nature of the role of advocates within Ralphs Close, and the absence of any agreed terms of reference with regard to their role. In the absence of further information reviewers could not therefore be assured as to how the input of the advocates strengthened the global protection plan.

RECOMMENDATION

9. The Western Trust should consider formal independent advocacy arrangements for the residents in Ralphs Close. Advocates should be experienced in working with individuals who are non verbal but who communicate in a variety of different ways.

4.5 Risk Management Arrangements

During the review, senior managers were able to demonstrate the governance process for highlighting concerns within the learning disability service. The

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Raising our Sights; services for adults with profound intellectual and multiple difficulties. Department of Health, Professor Jim Mansell (2010)

review team was made aware of a clear governance structure within the Western Trust. It was explained how concerns in the service progressed through the structure to the trust's Governance Committee which is chaired by the Trust Chair. It was also explained how this system was used to highlight risks and place risks on the trust's risk register.

The review team was therefore concerned that Ralphs Close had not featured on risk registers. An understanding of the significant challenges and risks involved in the change of culture from a congregated hospital ward to a residential home providing social care was not evident. Reviewers were informed of the ongoing staffing difficulties, problems releasing staff for training, and low reporting of incidents. Any of these factors warrants an alert on a risk register. The combination of these would suggest the need to examine the significance of these risks, and to ensure that there is a corporate focus on addressing such concerns.

Managers who were interviewed stated that there was little need to discuss Ralphs Close at governance meetings as all seemed well. As indicated above there are inherent risks in the development of a service such as Ralphs Close. Had Ralphs Close been a regular item for discussion at one or more governance groups, the likelihood of poor practice may have been reduced.

4.6 The Role of Non- Executive Directors

Issues of potential concern can often be highlighted by an external and independent visitor. This can often be a role undertaken by non-executive directors of a trust who will be able to maintain a corporate interest on issues identified. Previous enquiries into learning disabilities services in the United Kingdom have recommended that non-executives can play a significant role by reporting to trust board through a programme of visits in learning disability services.[6]

RECOMMENDATIONS

10. Western Trust governance structures should be used to ensure that there is a corporate understanding of the risks in changing a culture in the way that the move to Ralphs Close warranted and that appropriate action is taken to address them.

11. The Western Trust should consider developing a rolling programme of visits to Ralphs Close by trust non-executive directors.

[6] Report of the NHS Review of Commissioning of Care and Treatment at Winterbourne View: NHS South of England. (August 2012)

5. Staffing and Training

A number of contextual staffing issues were identified during this review, which, in the view of the review team, contributed to undermine sound governance arrangements.

It was evident that the Western Trust was experiencing difficulties in the recruitment and retention of staff at Ralphs Close. It was reported during the interviews that there was a heavy reliance on agency and bank staff. One interviewee reported that on one shift there were no established team members. The review team considers that this is an unsatisfactory situation. Stability and consistency of approach for the care of residents in the home is undermined. Furthermore key trust governance processes such as incident reporting and staff compliance with mandatory training may be compromised.

In addition, it was brought to the review team's attention that senior management within the Learning Disability Programme had been made aware of this issue. The review team was not made aware of any trust action to address this issue, and did not find evidence that this staffing deficit appeared in any risk register.

Issues relating to staff training were raised during the course of the interviews, and it was reported to the review team that recent RQIA regulatory inspections within learning disability in the trust had identified deficits in vulnerable adult training.

The Western Trust has attempted to respond to this shortfall through the provision of targeted training. However, from the information received, the review team could not be assured about the uptake for this training by staff within Ralphs Close.

Reviewers were concerned that similar deficits exist in the provision of training in restrictive practices and physical intervention.

Most significantly, it was evident that little training had been delivered to help the manager of the home and the staff understand the change in culture from hospital to residential care home. It would have been helpful, if before the move to Ralphs Close, the manager and some staff had been provided with opportunities to work in residential settings and thereby transfer good practice to Ralphs Close.

RECOMMENDATIONS

12. The Western Trust should review its recruitment strategy within Ralphs Close with regard to reducing its reliance on the use of agency staff

13. Training should be commissioned by the Western Trust to assist staff in understanding the cultural differences between the provision of hospital care and the support of an individual to be as independent as possible in a residential care setting.

6. Summary of Recommendations

1. The Western Trust should keep decisions regarding the precautionary suspension of staff under continuous review throughout an investigation as new evidence emerges.

2. The Western Trust should review the monitoring arrangements at Ralphs Close to ensure that the monitors are independent of the staff working there.

3. The Western Trust should examine the potential for collaborative arrangements with learning disability services in other trusts and/or voluntary sector providers to assist with the provision of skilled and independent staff in times of crisis.

4. The Western Trust should put arrangements in place to ensure that staff and managers are aware of the need to report all incidents in Ralphs Close. Regular incident reports should be delivered to managers in a format that enables them to examine trends and discuss appropriate measures with the staff team.

5. A system of regular reviewing of all restrictive practices in Ralphs Close should be developed by the Western Trust. This should result in a monitoring report being presented to the learning disability governance group at agreed intervals.

6. The Western Trust should ensure that all staff undertake appropriate training and refresher training in incident reporting, restrictive practices, vulnerable adults and physical intervention.

7. The Western Trust should ensure there are arrangements in place to provide management oversight, support and training to the manager in Ralphs Close in making important decisions about the reporting of incidents, vulnerable adult investigations and restrictive practices.

8. The Western Trust should consider how to improve engagement and interaction with the residents to lessen the need for restrictions and physical interventions.

9. The Western Trust should consider formal independent advocacy arrangements for the residents in Ralphs Close. Advocates should be experienced in working with individuals who are non-verbal but who communicate in a variety of different ways.

10. Western Trust governance structures should be used to ensure that there is a corporate understanding of the risks in changing a culture in the way that the move to Ralphs Close warranted and that appropriate action is taken to address them.

11. The Western Trust should consider developing a rolling programme of visits to Ralphs Close by trust non-executive directors.

12. The Western Trust should review its recruitment strategy within Ralphs Close with regard to reducing its reliance on the use of agency staff.

13. Training should be commissioned by the Western Trust to assist staff in understanding the cultural differences between the provision of hospital care and the support of an individual to be as independent as possible in a residential care setting.

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