

Southern Cross, Orchid View

September 2009 – October 2011

An analysis of the Care Quality Commission's responses to events at Orchid View identifying the key lessons for CQC and outlining its actions taken or planned

June 2014

Contents

Foreword from the Chief Inspector of Adult Social Care	2
Introduction	5
Listening to relatives	5
Context	6
Summary of the sequence of events and CQC's actions	7
Findings	9
Including causal factors, lessons learned, changes since 2010-11 and action planned	
Conclusions and commitments for improvement	25
Appendix: Investigation terms of reference and methodology	27

Foreword from the Chief Inspector of Adult Social Care

In October 2013, the inquest into the deaths of 19 people living at Orchid View care home concluded that neglect had contributed to the deaths of five residents with other residents suffering 'sub-optimal' care. Newly into my post as Chief Inspector of Adult Social Care at the Care Quality Commission, I was appalled by the descriptions of what had happened at Orchid View. My first thoughts were with the people and their families who had suffered this unacceptable care. But the coroner had also criticised the actions taken by CQC during 2010-2011 and I was determined to take a long, hard look at our role and make sure that any lessons to learn were turned into practical action.

This report is the product of that review. Adopting the formal technique of root cause analysis, we identified the key points where CQC was involved, considered the action we did take, explored why and reflected on any alternative action we could have taken. We also identified what has already changed since Orchid View closed in 2011, the lessons we have learned and further action planned. This is particularly important as we are testing and consulting on our new approach to the regulation and inspection of adult social care and I want to make sure that any further action is fully reflected in our new plans.

When things go wrong in health or social care services, families affected want to make sure that others do not have the same experience. To do this, we need to be honest about our mistakes, be clear about changes that are needed and then make sure they happen.

The report is a difficult read for those of us at CQC and even more so for the families of those living at the home, but we want to be open about our role and what we have done in response.

While the responsibility for the unacceptable care that happened at Orchid View rests squarely with the people providing the service and their owners, Southern Cross, it is clear that in 2010/11 CQC did not fulfil its purpose of making sure the service provided people with safe, effective, compassionate, high-quality care. The way we worked in 2010/11 meant we did not respond proactively to early warning signs, were too easily reassured by the responses of the provider and did not take appropriate enforcement action quickly or strongly enough.

It is over two and a half years since Orchid View closed and the report highlights that since then, CQC is more responsive to safeguarding and other notifications of risk; our inspection techniques have improved; training has been provided in relevant areas; and working with local partners has been strengthened. But we can and should do more and our new approach will take these improvements further.

There are specific actions for CQC:

- Ratings in the new approach will not be awarded if there is insufficient evidence to do so – for example, very low occupancy as in the case of Orchid View.
- Arrangements for quality assurance and monitoring of inspections will be strengthened and specialist teams of inspectors established with smaller portfolios of services to improve regulatory risk management.
- Information systems will continue to be developed so that data collection and analysis is improved, worrying trends more clearly identified and a history and chronology of events for every location is easily accessible to inspectors and managers.
- Information provided by people using services, their families and carers as well as staff who raise concerns will be used to help focus inspection activity.
- Inspections will ask five key questions – is the service safe, caring, effective, responsive and well-led? Guidance will be provided to inspectors to support more consistent and robust gathering of evidence.
- Additional inspectors will be recruited, and resources have been made available to enable this.
- Clear information on the outcome of inspections will be given to providers and shared publicly to encourage improvement.
- Enforcement action will be taken and the full use of our powers deployed when this is required to secure improvement, constraints or closure of services.

CQC's failings in 2010/11 were not the fault of any one individual. The analysis and the actions set out in the report show that the wider circumstances at the time (organisational change, activity pressures, regulatory changes and poor information systems) all contributed to some poor and delayed decisions and we absolutely need to make sure that we do better in future. In this context it would be inappropriate to single out any individual, as the responsibility for the failures in relation to Orchid View rests with, and is accepted by, the organisation corporately.

Since we carried out this review there have been more recent reports of poor care in residential care homes such as reported in the BBC Panorama programme 'Behind Closed Doors: Elderly care exposed'. That programme revealed neglect, verbal abuse and physical violence against people who were frail and vulnerable. It has, quite rightly, provoked a lot of reaction and comment. CQC's inspections are periodic and therefore deliberate acts of poor care or abuse are unlikely to take place in front of an inspector, although we need to be aware of the culture of organisations, which may allow neglectful or abusive practice to persist. The major responsibility for high quality, safe, compassionate and effective care rests with the people running the services and the staff working there as well as with those who commission them. The events at Orchid View that were the subject of this review and report were the result of very different circumstances, when signs of poor practice were not acted upon by the provider or CQC and we have identified gaps in our systems that allowed them to go unchecked. The focus of this review has been to address these gaps.

Before I close, I would like to thank the primary authors of this report, Paula Mansell and Steve Holmes, and everyone they worked with throughout the organisation to reflect honestly on what happened and where we need to improve.

I would also like to thank the families of the Orchid View residents who met with Adrian Hughes, Deputy Chief Inspector during the review. The families told us that CQC must have a higher profile; it should be responsive when concerns are raised and make sure relatives and others are kept informed. These important principles will continue to underpin our work. CQC will always act on the side of people using services, their families and carers, and will ensure that the issues raised by them and the information they share with us is used to inform our regulatory and inspection activity and the action we take.

I am determined, as is the rest of the Board and senior team, that CQC will never again, as it did at Orchid View, lose sight of its central purpose to make sure that care services provide people with safe, effective, compassionate and high-quality care whatever the extent of organisational change taking place at CQC, whether or not individual inspectors change over a period of time, and however complicated circumstances at a particular home might be.

Nothing we can say or do now will change what happened at Orchid View between 2010 and 2011. But the best way CQC can honour the memory of those who died is to use our learning to improve the way we regulate and inspect adult social care and to encourage services to improve for the benefit of everyone who will use those services now and in the future.

A handwritten signature in black ink, appearing to read 'Andrea Sutcliffe'. The signature is stylized with a large initial 'A' and a long horizontal stroke at the end.

Andrea Sutcliffe
Chief Inspector of Adult Social Care
June 2014

Introduction

Orchid View was a care home in West Sussex that was registered with the Care Quality Commission (CQC) from September 2009 to October 2011. The home, run by Southern Cross, provided care and nursing for up to 87 people who were elderly, frail, had nursing, or dementia care needs.

The home closed in October 2011 following a number of serious safeguarding concerns over the two years that it was open. In October 2013 a coroner's report ruled that neglect had contributed to five resident deaths, with other residents suffering 'sub-optimal' care. The report said that the home was mismanaged and understaffed. The coroner also criticised CQC for failing to identify the failings at the home prior to its inspection in September 2011 and not taking action to close the home prior to its voluntary application to cancel its registration resulting in closure in October 2011.

Following the coroner's report, a Serious Case Review (SCR) commenced to consider the practices of all the agencies that had a role in safeguarding residents at the nursing home and to ensure that the lessons learned are being actioned by all the agencies involved. CQC submitted an Individual Management Review to support the SCR in December 2013. The overall report from the SCR published in June 2014 and the further recommendations for CQC arising from the SCR are being taken into account.

From the Individual Management Review, it was clear that there were a number of missed opportunities where CQC could have taken action. As well as contributing to the SCR, CQC decided to carry out its own investigation to ensure the learning could inform the development of its new regulatory approaches and to publicly report its findings and planned changes.

This investigation sets out the events leading up to the closure of the home and looks at points where CQC as the regulator could have done more to protect the people living at Orchid View. This investigation report identifies what we needed to change, what has already been done and how we are taking action to ensure we protect people in the future.

Listening to relatives

CQC has had an opportunity to meet directly with the families of people who were affected by the care provided by Southern Cross at Orchid View as well as a meeting with lawyers representing them. They told us that not only must CQC have a higher profile; it must also be responsive when concerns are raised and make sure that relatives and others are kept informed. The publication of reports is vital in helping families to make choices, but it is vital that information on our website is updated when concerns are raised. The families welcomed our commitment to continue to engage with them to hear first-hand their views on the changes we are proposing.

Context

The Care Quality Commission (CQC) was formed on 1 April 2009 as the independent regulator of health and adult social care services in England. CQC registers health and adult social care services across England and inspects them to check whether standards are being met. We publish reports of our findings on our website. In between inspections, we should monitor the information that we receive and hold about a service. The information comes from our inspections, the public, care staff, care services and from other organisations.

During the period covered by this review, there were significant changes to the underpinning legislation, policy and methodology within which CQC operated and providers were registered and regulated. As part of the changes, CQC was required to register approximately 25,000 existing service providers during 2010/11. This was a significant undertaking for CQC and it has since acknowledged that this work had a major negative impact on the number of inspections undertaken from June 2010 to April 2011. There were arrangements in place at the time which were designed to ensure that the events at Orchid View during this period would not have gone undetected. However, the checks built in were triggered too late in this case. There were gaps in our systems that allowed poor care to continue before we took appropriate action.

Since then, and following extensive consultation, CQC has more clearly defined and published its role to make sure health and adult social care services provide people with safe, effective, compassionate, high-quality care, and we encourage care services to improve. We aim to put the views, experiences, health and wellbeing of people who use services at the centre of our work, and we have a range of powers we can use to take action if people are getting poor care.

During the two years that Orchid View was open, it remained the responsibility of Southern Cross to ensure it was compliant with all the regulatory standards and to report any deaths, illnesses or other untoward incidents to CQC. Such notifications, together with concerns or complaints raised about the service, should have been used by CQC to inform the timing and scope of inspections of the service.

Summary of the sequence of events and CQC's actions

This is a review of the actions that CQC took in response to the information it had at the time. The SCR has reviewed the information held and actions taken by all the agencies involved during the period under review.

Southern Cross opened Orchid View care home and it was registered with CQC in September 2009. It was given a 'good' rating after its first inspection by CQC in January 2010. The inspection report described it as being a well-maintained home, where staff were knowledgeable about residents and where complaints were responded to promptly. At the time there were 16 residents living at the home out of a total of 87 places available.

Between March and July 2010, CQC was aware that the local authority had carried out a number of safeguarding investigations regarding allegations of institutional abuse and the neglect of five residents, including two residents who had died and were the subject of a coroner's enquiry. As a result of these concerns, the primary care trust (PCT) stopped placing any new residents in the home in March 2010.

During this period other concerns and notifications continued to be raised with CQC by the local authority, a social worker, a relative of a resident and the service itself. At the same time, CQC was preparing for significant changes to its governing legislation.

In August 2010 Southern Cross submitted its application for Orchid View to register against the new standards as part of the changes to legislation from the Care Standards Act 2000 to the Health and Social Care Act 2008. The provider's application stated that the home was fully compliant with all the new standards. CQC challenged this declaration of compliance, but when Southern Cross provided further information CQC accepted the assurances and completed its registration of Orchid View at the beginning of September 2010.

Following registration in September 2010 there continued to be a number of reports of incidents and concerns which resulted in the dismissal of two members of staff, serious injury to a resident as a result of a fall, and incorrect medication administration to a resident. As a result of the concerns, CQC requested information from Southern Cross, which was supplied in January 2011. This set out improvements Southern Cross had made as a result of the findings of the investigation, including the appointment of a new manager at Orchid View.

CQC received further safeguarding concerns about residents in Orchid View in February and March and complaints from relatives in May and June 2011 about poor care practices, medicine administration and management of the service.

CQC carried out an inspection in June 2011. The home was judged to be failing to comply with six standards, four were judged to be of minor impact, including staff training, treating residents with dignity and respect, medication management and meeting nutritional needs. The home was judged to be non-compliant with moderate impact in the standards about

the care and welfare of residents and staffing levels, but the inspection did not identify failings judged to be major during the inspection.

In August 2011, CQC received a letter from a whistle blower sent to CQC, the PCT and local authority, raising concerns about the lack of qualified staff and poor medicines management. In response the PCT and the local authority undertook a review of recent deaths in the home.

CQC returned to inspect the home in September 2011 in response to the ongoing concerns and found major failings against eight standards, with residents left at risk of serious neglect due to poor continence care, pressure relief and pain management, and failure to support people to eat and drink sufficient amounts. It found continued concerns about administration of medication, not enough staff on duty to meet residents' needs and inadequate training and management.

A Management Review Meeting (MRM) was held by CQC staff and a decision was made to issue Warning Notices for breaches of the seven regulations. A further inspection was planned for 1 November to check that improvements had been made.

Before that inspection could take place, Southern Cross applied to cancel their registration for Orchid View and the home closed in October of that year, shortly after the publication of the last inspection report.

The deaths of 19 residents were the subject of a coroner's enquiry. Published in October 2013, the coroner's report concluded that all of those residents died from natural causes but all had suffered "sub-optimal" care. The report concluded that five of those who died from natural causes "had been contributed to by neglect".

Findings

The findings are set out under the headings of nine key points in the chronology identified as requiring further analysis. These were:

1. In January 2010 an inspection at Orchid View rated the home as 'Good'.
2. CQC's response to concerns received during the period from March to mid-July 2010.
3. The transition registration in September 2010.
4. Internal Management Review Meeting in December 2010.
5. CQC's management of ongoing concerns between February and April 2011.
6. The service inspection of Orchid View on 27 June 2011.
7. CQC's collaboration with partners and its response to escalating concerns between July and August 2011.
8. The internal Management Review Meeting and enforcement decision on 23 September 2011.
9. Safety concerns reported following the Management Review Meeting up to the closure of Orchid View in October 2011.

1. In January 2010 an inspection at Orchid View rated the home as 'Good'

Orchid View was first registered with CQC as a care home with nursing under the Care Standards Act 2000 on 1 September 2009. The registered provider was Southern Cross (Cophorne) OPCO Ltd. It was registered to accommodate 87 people who were elderly, frail, had nursing, or dementia care needs.

The registration process did not identify any concerns with Orchid View. The first inspection of the home by CQC took place in January 2010, within six months of the service opening, in line with the existing guidance at the time. There was a registered manager in place who was a general nurse. At the time, only 16 residents were living in the home. There was some limited reporting of the experience of care. One visitor was reported as saying there were not always enough staff on duty. The only issue raised in the report was that staff supervision records were not completely up to date which, it said, the manager was addressing. At the time there was no clear requirement for inspectors to record the views of residents and report their individual experiences. Nor was there a clear requirement to collect and record the views of other professionals or partner agencies.

The home was awarded a 'Good' rating, despite operating well below capacity. This influenced the planned frequency of future scheduled inspections. For Orchid View this would have meant another inspection would not have been planned for at least a year. In addition the inspection report focused on policies, procedures and records. There were no recorded discussions with any residents or external professionals in the report.

Causal factors in 2010-11

- There was no guidance for staff about inspecting a service that was not fully operational and occupied. This meant that the available evidence was limited and this resulted in a 'false' assurance of the quality and effectiveness of the care being provided.
- At the time, there were staff shortages at CQC and a high turnover of inspectors and managers. As a result, inspectors were responsible for a higher number of services and were under pressure to meet inspection targets.
- There was difficulty obtaining information /overview about the parent company (Southern Cross) from the existing system, which only showed information about the newly opened Orchid View home.

Changes since the closure of Orchid View

- Gathering the views of stakeholders and partner organisations is now standard CQC practice.
- Case tracking and seeking the views of people who use services is now an explicit component of inspections of care homes.
- Information about concerns relating to parent companies is now more readily available through reports from the Corporate Provider Compliance teams to inform inspections.

Lessons learned from this review

- The outcome of an inspection and the subsequent rating if the service is new or operating below capacity must be treated with caution.
- Inspection frequency decisions should be based on 'real time' information including notifications, safeguarding information and other concerns about a service. Judgements from past inspections should not override more relevant current information about a service.

Action planned

- The new inspection models and judgement framework being developed as part of the new approach to adult social care inspection will ensure more consistency and robustness in evidence gathering.
- Continued recruitment of additional inspectors will further reduce workload pressures.
- The new approach to quality rating services recognises that sometimes it is too soon or not possible to have sufficient evidence to be able to rate a service and therefore a rating will not be awarded until the appropriate time.

2. CQC's response to concerns received during the period from March to mid-July 2010

Between March and July 2010, CQC was notified that the local authority had carried out a number of safeguarding investigations in relation to concerns about poor administration of medicines, staffing, poor care practices, neglect and concerns around the speed of the provider's response to issues raised. Some of these notifications had been received directly from the provider but most were notified to CQC by the local authority. As a result of these concerns the PCT stopped placing any new residents in the home.

In June 2010, CQC received the results of the safeguarding investigations undertaken by the local authority into the alleged neglect of five residents. Two of the allegations concerned residents whose care was subject to the coroner's enquiry, which concluded that neglect played a part in their deaths. The allegation of neglect was upheld by the local authority in the case of one resident but CQC recorded the findings of the local authority as inconclusive in relation to the other four residents.

CQC received a report in July 2010 from an overarching investigation of the service by the local authority into staffing issues and possible institutional abuse. CQC's interpretation was again that the outcomes were inconclusive. CQC also received a complaint about a change of management, alleged cuts to staffing levels and about the quality of care. At the beginning of August, CQC was told that the local authority had convened a safeguarding strategy meeting and that the police were investigating allegations that a resident had died following a medication error involving a controlled drug.

These events failed to prompt CQC to escalate concerns or take action to inspect the home.

Causal factors in 2010-11

- There was no easily available overview available to inspectors of the history, concerns or activity at a location through the data management system.
- There was no automatic alert system to identify high numbers of notifications at an individual service.
- At that time, CQC was inconsistent in its use of new policies regarding its regulatory responses to safeguarding concerns and engagement with safeguarding investigations.
- There was significant pressure on inspectors due to urgent transition targets, together with large portfolios of 70-80 organisations across all sectors.
- There was inconsistent sharing of information with partner organisations which meant that the PCTs were not always contacted for views on a service.
- There was some uncertainty over processes, particularly the responsive action CQC could take due to the transition arrangements.

Changes since the closure of Orchid View

- Quality and Risk Profiles (QRPs) for adult social care services were introduced in 2011. These provided estimates of risk for all adult social care locations for each of the standards of quality and safety. They also provided a summary of the information held by CQC about a location. In February 2013 changes were introduced to the QRPs that included a new inspection history, correspondence timeline and flagged events page.
- Periodic team and management reports were introduced in 2013, which identified services with potential risks, including high numbers of safeguarding concerns.
- CQC safeguarding guidance to staff was revised and a process to track and review active safeguarding concerns was introduced in 2012. A revised safeguarding training package was made accessible to all inspectors in 2013.
- External engagement with partners is better organised as CQC is now involved and represented on every Quality Surveillance Group. These are groups across the country that bring together different parts of health and care economies locally and in each region in England to routinely share information and intelligence to protect the quality of care patients receive.
- The CQC Academy has been established to ensure that staff have the core training and development they need as well as specialist training for different health and care sectors.

Lessons learned from this review

- Managerial oversight and supervision of inspectors is crucial and must be maintained during periods of change to ensure escalating regulatory risks are identified and effectively acted on.
- Action by local commissioners, such as in this case when the PCT stopped referring people to the home, should act as a trigger for CQC to review information held about a service and consider responsive action.
- Periods of re-organisation are likely to disrupt relationship management and effective sharing of information.

Action planned

- An adult social care reporting tool will be developed by October 2014 to enable inspectors to easily see in one place a chronology of historical and current safeguarding notifications and other concerning information about a service.
- For the new approach to social care inspections that started in April 2014, key evidence summaries are being tested and evaluated with regard to supporting the information packs for inspection planning.
- A management development programme will include a revised approach to quality assurance and monitoring of inspections.
- Safeguarding training will be rolled out to all inspectors through CQC's Academy. Training includes information sharing, partnership working and ensuring we learn from previous failures to take action.

- Partners and stakeholders will be told which person or team in CQC will have responsibility for monitoring their care services during 2014 to ensure continuity of relationship management and sharing of information.

3. The transition registration in September 2010

This was an unusual period as the entire health and social care regulatory framework was replaced. All existing adult social care services were required to change their registration, and CQC to change its regulatory and enforcement policies and practices. The transition registration process was designed to process the transition applications of approximately 25,000 existing providers during 2010/11. In hindsight the process and timescales lacked the flexibility to manage concerns that had not been escalated by the regional team. Transition registration applications were processed by inspectors who did not know the service and there was considerable pressure to complete the process quickly.

Southern Cross submitted its application for transitional registration for Orchid View in August 2010, in which it declared full compliance with all the regulations. As part of the application Southern Cross advised CQC for the first time that there was no registered manager in post.

CQC challenged this declaration of compliance in light of the known safeguarding investigations and, as part of the registration process, initially judged there to be moderate concerns with four of the Essential Standards concerning care planning, medication, safeguarding and complaints handling.

Southern Cross was asked to supply further information about action it had taken in response to the outcomes of previous safeguarding investigations and to confirm if referrals by the PCT (or local authority) were still suspended. Southern Cross summarised the training and auditing it intended implementing or planning but acknowledged it would not be fully compliant in two outcomes (care planning and safeguarding) until staff training was completed by November 2010. Southern Cross confirmed that the local authority had suspended new placements at the home but that they were seeking to get this lifted at an upcoming meeting with the local authority.

CQC completed its registration of Orchid View at the beginning of September 2010, revising its concerns to minor for two standards. CQC issued an improvement action and requested an action plan from the provider. A restrictive condition was applied at registration to require there to be a registered manager in the home by 1 January 2011.

This was a missed opportunity to record, highlight and escalate the seriousness of the known concerns about Orchid View so that regulatory action would be swiftly triggered.

Causal factors in 2010-11

- The transition registration process was a significant undertaking that was supported by staff who were moved into registration with little experience of the process.
- Timescales were short and there was pressure to register services as quickly as possible.
- Management of the transition process for big corporate providers, including applications for each regulated activity, was a complex new process often managed by one member of staff inexperienced in registration procedures.

Changes since the closure of Orchid View

- Absence of a registered manager at a service is now one of our key indicators for risk. CQC has revised the guidance to staff about how to respond to providers who are required to have a registered manager in place and fail to do so, and the actions inspectors are expected to take.
- A registration handbook was produced in 2013 which set out how to ensure all information about the provider is considered when registering a location.

Lessons learned from this review

- The risks associated with periods of change such as the new period of transition with new legislation in 2014, should not be underestimated. CQC has appointed a Director of Transformation and a Head of Operational Transition. This role is responsible for ensuring the transition to our new structure and new model is a coherent and logical process. The process will ensure that knowledge is passed on, line management changes happen smoothly, and we don't miss significant alerts that could mean service users are at risk.

4. Internal Management Review Meeting in December 2010

In October 2010, CQC received notifications from Southern Cross about two separate incidents concerning two services users who were reported to have been shouted at by a member of staff, who was subsequently dismissed. There was also a notification of a serious incident received from the service about a resident who had fallen in her room and had dislocated her shoulder, which required surgery.

In early December 2010, the inspector attended a safeguarding meeting held by the local authority regarding the outcome of an investigation concerning the resident who had died following the medication error involving a controlled drug in August. The meeting concluded that the overdose did not have a significant effect on the resident's death, so the police investigation ended and the charges against the manager of the home were dropped. The allegations about the error were nevertheless substantiated and Southern Cross had dismissed the manager who had administered the medication in error.

CQC policy is that serious issues arising within a regulated service must be addressed with a Management Review Meeting (MRM) to assess the information and risks, and to determine and record the regulatory action that CQC will take in relation to the matters raised. A new inspector took over the CQC management of Orchid View at this stage and held an internal Management Review Meeting (MRM).

In this case, the MRM focused on the recent safeguarding meeting rather than considering the history of escalating concerns and potential underlying issues. CQC wrote to Southern Cross in early January 2011 to ask for an explanation of how the incident occurred and what measures Southern Cross had put in place to prevent reoccurrence.

CQC accepted the response from Southern Cross outlining the actions it had taken with regard to the individual concerned, including referring them to the Independent Safeguarding Authority (ISA) and the Nursing and Midwifery Council (NMC). In addition the police were taking no further action.

At the end of January 2011, CQC received the action plan for Orchid View from Southern Cross. The plan detailed the disciplinary actions they had taken in relation to the previous safeguarding concerns and the additional senior staff they were appointing with specialist responsibilities to strengthen management and auditing at Orchid View.

Southern Cross also reported appointing a new manager at Orchid View who had begun making arrangements for training for staff in palliative care and end of life care. The submitted action plan suggested that most of the identified action had been completed.

It appears that at the time CQC was satisfied with the action the provider had taken. At this time, the information held by CQC about the history of concerns at this service should have prompted an in-depth inspection early in 2011 to check compliance, irrespective of actions other agencies may have been taking to safeguard individuals or to restrict making placements.

Causal factors in 2010-11

- The process for holding MRMs was often rushed with insufficient planning time and pressure to hold them quickly and make quick decisions without time to reflect
- There was insufficient management overview of information of concern at location and provider levels
- Inconsistency of investigative skills in the team in terms of information gathered and considered prior to and during the MRM
- There were no standard handover procedures for inspectors particularly in periods of organisational change and no readily available overview in the data management system to allow a new inspector to see the history and activity including notifications in a service.

Changes since the closure of Orchid View

- Auditing of MRM practice has been undertaken and identified gaps as well as good practice. This resulted in revision of the process. There has been training for managers in the management of MRMs.

Lessons learned from this review

- Decisions made to take action or not during an MRM must be recorded. The decision making process and rationale for any course of action must be clearly set out and documented.

Action planned

- We are strengthening our enforcement processes and appointing inspectors with a lead role in enforcement to provide additional support and guidance to inspectors.
- Introduction of a new CQC enforcement data management system will provide ongoing records of concerns and prompt wider consideration.
- Revised risk reporting is being implemented to ensure effective handover during the current CQC transition to the new inspection directorates and teams.
- Revised processes for managerial oversight and supervision of inspectors is part of the new approach to ensure escalating regulatory risks are identified and effectively acted upon.

5. CQC's management of ongoing concerns between February and April 2011

At the end of February 2011 another safeguarding alert was received concerning a resident. A further notification concerning another resident was received in early March. CQC received an unexpected death notification at the home from a hospital in March 2011. CQC was also regularly receiving 'expected death' notifications from the home throughout this period.

In response to these concerns, CQC started planning for an inspection, but due to the serious illness of the inspector this stopped. A new inspector was allocated to Orchid View in April 2011. This was the third inspector allocated to this service since its initial registration in 2009. There was no handover between inspectors to flag the service as needing an urgent inspection in response to the serious concerns.

The notifications received by CQC, and required under regulations, represented most of the communication between the home and CQC for most of the period under review. With regard to the adult safeguarding notifications from the home, there appears to have been some reporting by the home in line with the regulatory requirement throughout the period but not all the safeguarding concerns were reported. The provider was also reporting deaths during the period but this too seems to have been incomplete. As a matter of

course CQC automatically closed notifications of 'expected deaths' and whilst inspectors were guided to review information about unexpected deaths, in practice this was usually inconclusive unless also subject to a safeguarding investigation.

CQC did not have an effective mechanism during this period for reviewing the scope and trends of safeguarding and death notifications to alert the inspector to escalating concerns or systemic patterns. The ability to easily produce this information combined with a summary chronology would have significantly added to the picture of the service and should have prompted an earlier second inspection of the service.

There was a failure to act on further escalating risks and concerns.

Causal factors in 2010-11

- There was a second unexpected change to the inspector with responsibility for Orchid View with no formal system for recording handover from one inspector to another.
- There was a lack of easily accessible overview of the history or escalating activity at location meaning that escalating risk was harder to identify added to the pressures of high portfolio allocations and the need to cover vacancies at the time.
- Inspectors had variable skills in use of the IT system, including where to find all elements of recent and historical activity.
- Whilst there were concerns about the provider within CQC, this information was not always available to all the inspectors who were responsible for different service locations.
- There was a lack of consistency in managing information in the Quality and Risk Profiles (QRP) for services – resulting in coding positive or negative information incorrectly.
- There was no 'flag' for outliers in terms of safeguarding notification.
- Risk registers relied on identified risk so could miss a case such as this – often only identified due to inspection activity.
- New processes at the time that were unfamiliar to staff.

Changes since the closure of Orchid View

- Attention to and analysis of safeguarding enquiries has vastly improved due to increased training and awareness. The QRP included notification indicators which would identify if a service had more safeguarding or death notifications than would be expected for a similar service.
- A Corporate Provider team was established to provide oversight of the larger corporate providers (approximately 34) whilst monitoring those considered to be of a medium size against a number of risk indicators. Regular monitoring reports were provided to regions following engagement meetings and outputs from the monthly panel meeting, which reviewed in detail data available to the regions on providers.
- The criteria for services to be reported on risk registers has been expanded to ensure all significant risks and actions planned are recorded.

- We have better processes in place and staff are more familiar with the data management system (CRM); we undertake regular audits to make sure that staff are following CRM appropriately.

Lessons learned from this review

- Unplanned changes of inspectors with responsibility for a service should prompt a review of the history and recent activity at a service.
- Where a provider has several locations in different areas, information about that provider must be available to inspectors responsible for individual service locations.

Action planned

- The new CQC methodology includes smaller portfolios and line management arrangements to strengthen regulatory risk management. Further inspector recruitment is underway but it will take time to achieve the target adult social care portfolio sizes of approximately 35-40 services.
- Inspectors will specialise in sectors from April 2014 and undergo training for the new methodology in their specialist areas. Additional protected training time will be provided for all inspectors over the next two years through the CQC Academy.
- Inspector and manager responsibilities will be clarified and strengthened in relation to identifying and responding to regulatory risks as part of the arrangements for the move to our new approach to inspections.
- Large corporate providers will each be assigned a Deputy Chief Inspector to hold the lead regulatory relationship and ensure knowledge is shared.
- Medium and small providers will be assigned an Inspection Manager to hold the lead regulatory relationship and ensure knowledge is shared.

6. The service inspection of Orchid View on 27 June 2011

On 31 May 2011, CQC received a copy of a complaint sent to the service by a relative of a resident. The complaint raised concerns about poor care practices, medicine administration and management of the service. CQC spoke to the complainant, the provider and the local authority about the complaint. Further concerns were received from another relative of the same resident on 13 June 2011. In response, the inspector brought forward the planned inspection of Orchid View. In the meantime a further notification was received from the provider in mid-June 2011 about another unexpected death of a resident.

At this point it would have been expected that a Management Review Meeting would have taken place to take stock of the evidence and to plan the inspection. This did not happen.

The inspector carried out the inspection on 27 June 2011, there was an additional specialist pharmacy inspector due to the nature of the concerns about medicines management. The outcome of the inspection was that the home was judged to be failing

to comply with six standards, four with minor concerns, including staff training, treating residents with dignity and respect, medication management and meeting nutritional needs. The home was judged to be non-compliant with moderate concerns about the care and welfare of residents, and levels of staffing, but the inspection did not identify serious failings.

The CQC inspection report advised the provider that improvements were needed to achieve compliance with the six regulations. As a result an action plan was received from the service as to how they would comply with the Regulations.

There was a clear pattern of concern being raised by relatives of people using the service, other agencies and potential triggers from information including in notifications. Taken together, these should have escalated the level of CQC's concern and culminated in an overarching risk assessment leading to recognition of and response to the systematic failures and for swift enforcement action to be taken. The finding of stronger evidence earlier may have resulted in enforcement action to cancel the registration sooner.

Causal factors in 2010-11

- Staff were under pressure to complete high numbers of inspections quickly which sometimes meant the planning time was reduced.
- There was a lack of obvious systematic triggers in terms of history and concerns to inform and direct inspection planning.
- There was no clear overview of escalating risk at inspection team level.
- During the period of the review three different inspectors were responsible for the regulatory oversight of the home.
- It was not common practice to involve specialist nursing advice.
- There was a general lack of investigative skills to expand the scope of the inspection to follow up concerns and risk identified once on site.

Changes since the closure of Orchid View

- The numbers of inspectors has increased and training has improved understanding of systems and process.
- Inspectors have increased flexibility about which standards they choose to inspect based on risk and history but application varies across regions.
- Greater focus on the use of experts and who to include on the inspection.

Lessons learned from this review

- If the history of concerns had been fully understood and analysed, it should have alerted CQC to include a specialist with nursing experience in the team to test how well the home was meeting the needs of its residents.
- There is a need to ensure staff have 'permission' to pause and consider escalating concerns.

Action planned

- The new approach to inspecting adult social care services will include clearer lines of enquiry applied more consistently.
- Checking safeguarding concerns will be built into inspection planning.
- More routine use of specialist advisers on inspections of services which are caring for people with complex nursing needs.
- Investigative skills training to be available through a new Academy delivering a new approach to learning and development.
- A new safeguarding notifications indicator has been developed that will provide a comparison of the rate of safeguarding alert and safeguarding concern notifications per bed compared to the rate from similar service providers.

7. CQC's collaboration with partners and its response to escalating concerns between July and August 2011

On 29 June 2011, CQC received notification of an unexpected death of a resident from the service, but no untoward circumstances were advised. A further unexpected death notification of another resident was received at the beginning of August.

On 3 August 2011, the police contacted CQC to invite the inspector to attend a safeguarding strategy meeting about the home on the same day. The inspector was on leave and the urgency of the issue was not understood.

In mid-August, CQC received a letter from a whistleblower alleging a lack of qualified staff and poor medicines management at the home. In response the primary care trust (PCT) and the local authority undertook a review of recent deaths in the home. It was agreed that CQC would monitor the outcome of these investigations and the inspector attended a number of safeguarding meetings held by the local authority to follow the progress of their investigations.

The safeguarding strategy meetings show that the local authority and the health authority did initiate a large scale investigation of the service in July and August 2011 undertaking daily checks and care reviews at the service more or less until the service closed in October 2011. During this time, CQC was aware that the local authority had stopped all admissions to the home during August 2011. This should have initiated a Management Review Meeting to consider all the information and the action required.

The inspector at this time recalls attending most of the safeguarding strategy meetings held during the summer of 2011 and working closely with the local safeguarding teams. However, it is accepted that opportunities to provide greater clarity on the role of CQC staff about their contribution in the overall safeguarding response could have been taken. The CQC guidance on attendance at safeguarding meetings states that it is a decision for the inspector and their manager. During the previous year increased inspector attendance at case conferences could have been expected given the frequency of incidents and the likelihood of systemic problems at the home.

Causal factors in 2010-11

- There was a lack of consistent understanding of CQC's regulatory role in relation to safeguarding concerns and as a result there were variable responses by inspectors.
- Variable attendance at safeguarding meetings without clear record of the reasons for decisions to attend or not.
- Perception that it was an invitation for the inspector personally to attend a safeguarding meeting rather than 'CQC' as an organisation.

Changes since the closure of Orchid View

- Advanced safeguarding training is being rolled out to lead inspectors to clarify understanding and guide consistent responses.

Lessons learned from this review

- Partnership working with safeguarding and commissioning stakeholders is essential and should be monitored. Attendance at safeguarding meetings should not be dependent on the availability of one individual.
- CQC's safeguarding protocol sets out the standards and expectations but it is not applied consistently and is in need of a refresh.

Action planned

- There is a planned reorganisation of relationship management in terms of local authority areas.
- Increased supervision of inspectors by inspection managers is part of the new approach and built into the processes and staff training.
- The new Intelligent Monitoring processes include information from inspectors.
- Work is being undertaken to complete an engagement strategy to ensure better relationships at local level with clear escalation routes.
- We are making it easier for people to tell us about the care they receive and that we make use of this information in our work.

8. The internal Management Review Meeting and enforcement decision on 23 September 2011

CQC undertook another inspection on 20 September to follow up the non-compliance previously identified, and in response to the further concerns raised about the lack of staff and poor medicines administration. In addition to the two CQC inspectors who conducted the previous inspection, an NHS trust safeguarding practitioner with a nursing background was present at the home during the inspection.

The inspection identified major concerns with outcomes relating to respecting and involving people who use services, care and welfare of people, meeting nutritional needs, safeguarding people from abuse, management of medicines, staffing, and assessing and monitoring the quality of service provision.

On 23 September 2011 the CQC held an internal Management Review Meeting to decide what enforcement action to take. It found that although the provider had taken steps to improve the quality of care at Orchid View, there had not been a significant improvement in the care people were receiving in the home. This was around the time when Southern Cross had collapsed and it was anticipated that a different provider would be making an application to take over the running of the home from 1 November 2011.

The decisions taken at MRM were influenced by a number of factors:

- An expected early change of provider;
- All admissions into the home had been stopped;
- Some residents had already left and there were planned moves for others resulting in reduced numbers to be cared for;
- Southern Cross had significantly increased resources at the home;
- There continued to be close scrutiny and monitoring by external professionals;
- The likely difficulty of finding alternative placements if there was an urgent cancellation, normally within 72 hours, and closure by CQC;
- Southern Cross would in all likelihood no longer be the provider if cancellation followed the usual course.

CQC considered the option of applying for an Urgent Cancellation or a Notice of Proposal to cancel registration more slowly, but both these options were rejected given the factors listed above. The MRM decision was to serve Warning Notices for breaches of the seven regulations with the timescale for action and compliance by 31 October. If Southern Cross remained the provider then another inspection was to take place on 1 November. In addition to the enforcement action a letter was sent to Southern Cross advising them of the serious concerns that CQC had about the service.

Contrary to processes in place at the time, there was no record of the MRM setting out the reasoning as to why more urgent regulatory action wasn't taken. However it is clear that CQC failed to focus on its regulatory action due to the collapse of the provider organisation and the potential takeover of the management of the location by another provider.

Causal factors in 2010-11

- The processes for holding MRMs were often rushed with pressure to make quick decisions without time to reflect, together with poor recording and oversight of MRM processes.

- Unfamiliarity at the time with the processes for applying the available enforcement powers resulting in inconsistent enforcement decision making across regions / teams and a belief that there must be sequential steps to enforcement.
- Reluctance to take regulatory action to close a home when partners are taking action which in this case included a ban on new admissions and a transfer of services in progress.
- Over reliance on Warning Notices to enforce improvement even where CQC had little or no confidence in the provider.
- Lack of consistency and robustness in evidence collection.

Changes since the closure of Orchid View

- There has been training for managers in the management of MRMs.
- Enforcement training for all inspectors took place to promote good and consistent practice.

Lessons learned from this review

- CQC must not be distracted from the course of correct action due to periods of change or due to the action of other partner organisations.

Action planned

- Inspector and manager responsibilities will be further clarified and strengthened in relation to conducting MRMs as part of the training and processes as we move to our new approach to inspections and monitoring of services.
- We are strengthening our enforcement processes and appointing inspectors with a lead role in enforcement.

9. Safety concerns reported following the Management Review Meeting up to the closure of Orchid View in October 2011

Following the decision on 23 September to issue Warning Notices to Southern Cross there continued to be a significant number of notifications to CQC of incidents and concerns which should have prompted more immediate action. Instead Southern Cross voluntarily submitted an application to cancel its registration 14 October 2011. On 18 October 2011, CQC issued a Notice of Decision to the provider cancelling the home's registration after everyone had moved out.

It was inappropriate for CQC to accept and process a voluntary cancellation when Warning Notices had been issued. Instead there should have been an escalation of concerns and consideration of more urgent action.

Lessons learned from this review

- At the time, there was a tendency for regulatory action to be driven by the step by step process that was set out rather than by experienced consideration of escalating concerns. This should then be followed by appropriately targeted action to protect the safety of people. This resulted in a reluctance to take action to urgently close the service.

Action planned

- We are currently reviewing our process for seeking urgent closure when a service is due to close or to transfer to enable CQC to exercise stronger oversight.

Conclusions

The analysis of CQC's involvement with Orchid View has identified a number of areas where we must ensure that lessons are learned. Our role is to check that people like the residents of Orchid View are receiving safe, compassionate and high quality care. We missed opportunities during 2010 and 2011 that resulted in us taking too long to fully recognise the extent of the problems and the consequent risks to people at Orchid View. The gap between inspections in January 2010 and June 2011 was too long and a responsive inspection should have been triggered much sooner. Changes since 2010/11 mean that CQC is more responsive to safeguarding and other notifications of risk; our inspection techniques have improved; training has been provided in relevant areas; and working with local partners has been strengthened.

However there remain a number of lessons for CQC, these are set out in this report. We must be vigilant during another period of change to our organisational structure and regulatory framework and we must maintain our inspection activity. Whilst there has been progress in many areas we still have improvements to make with regard to our information systems and strengthening our workforce in the new structure. The future risk of lost information should not be underestimated during periods of re-organisation. The review has identified further improvements to be made to ensure that multiple concerns are recognised as an increasing indicator of potential systemic problems in services, and that these trigger the necessary responsive action appropriately. Even when CQC did consider the increasing concerns during transition registration in August 2010 and again in the Management Review Meeting in December 2010, CQC was too easily assured by the response from Southern Cross about action they were taking.

We have included in the report the changes that have already been made and set out the further action planned to ensure that the factors that led to the events at Orchid View are addressed and changes made.

There is little evidence that CQC periodically reviewed all the information it held about Orchid View during 2010/11, particularly at the points of changeover between inspectors. The investigation has identified that, whilst CQC was aware of concerns about Southern Cross as a provider, processes at the time meant this information was not routinely provided to inspectors with responsibility for the various sites and services that Southern Cross managed. In addition, configuration of the data management system at the time meant that inspectors did not have access to an up-to-date, comprehensive overview of all the incoming information of concern about a service over time. This has been identified as one of the key causal factors. In all probability, if this overview of safeguarding notifications had been available, it would have rung alarm bells and triggered an inspection much sooner.

Commitments for improvement

CQC has undergone a number of changes and improvement since Orchid View closed two and a half years ago. However, we can add to these improvements through our new approach and we have made a number of commitments in light of the findings in this report to ensure these improvements are made.

- Ratings in the new approach will not be awarded if there is insufficient evidence to do so – for example, very low occupancy as in the case of Orchid View.
- Arrangements for quality assurance and monitoring of inspections will be strengthened and specialist teams of inspectors established with smaller portfolios of services to improve regulatory risk management.
- Information systems will continue to be developed so that data collection and analysis is improved and worrying trends more clearly identified, and a history and chronology of events for every location is easily accessible to inspectors and managers.
- Information provided by people using services, their families and carers, as well as staff who raise concerns, will be used to help focus inspection activity.
- Inspections will ask five key questions – is the service safe, caring, effective, responsive and well-led? Guidance will be provided to inspectors to support more consistent and robust gathering of evidence.
- Additional inspectors will be recruited, and resources have been made available to enable this.
- Clear information on the outcome of inspections will be given to providers and shared publicly to encourage improvement.
- Enforcement action will be taken, and the full use of our powers deployed when this is required, to secure improvement, constraints or closure of services.

Appendix: Investigation terms of reference

Purpose

To identify key points during the two years when Orchid View was registered with CQC where an opportunity existed to take alternative action. To identify the causal factors and learning points to reduce the possibility of a similar occurrence.

Objectives

- To establish the events and CQC action during the two year period from registration of Orchid View in 2009 to de-registration in 2011.
- To establish the key points where there were opportunities for CQC to take action to protect residents.
- To understand why action was not taken by identifying the causal factors.
- To establish how recurrence of a similar series of events may be reduced or eliminated by identifying areas for improvements against a backdrop of changes to underpinning legislation, policy and processes during and since the events leading to the closure of Orchid View.
- To formulate recommendations and an action plan.
- To provide a report and record of the investigation process and outcome.

The investigation will be led by the investigation steering group, chaired by the Chief Inspector of Adult Social Care. It will include gathering information from people and processes in place at the time of the events. The events will be mapped onto a chronology of events to identify key points for causal factor analysis.

Improvements and solutions will be identified to address the key contributory factors identified.

The report will be published on the CQC website in April 2014.

The implementation and effectiveness of the solutions identified will be monitored.

Methodology

As part of the review of events leading to the closure of Orchid View care home, the CQC steering group reviewed evidence collected from staff, the CQC internal database, and the chronology of events spanning the two years from September 2009 to October 2011:

- ICAP and CRM records relating to Orchid View including all safeguarding, notifications and inspection activities.
- CQC inspection report for Orchid View dated 20 September 2009.
- CQC inspection report for Orchid View dated 28 January 2010.
- CQC registration report for Orchid View dated 7 September 2010.
- CQC Management Review Meeting record for Orchid View dated 17 December 2010.
- CQC inspection report for Orchid View dated 27 June 2011.
- Inspecting for better lives – Delivering change CSCI guidance for inspectors – Published July 2005.
- Judgement Framework CQC Guidance about compliance – Published March 2010.
- Setting the Bar: Monitoring of Compliance CQC Guidance for Inspectors – Published September 2010.
- CSCI Safeguarding Adults Protocol and Guidance.
- CQC Safeguarding Protocol – Published June 2010.

The steering group agreed key points in the chronology which required more in-depth analysis. A workshop to agree and analyse the key points was held in January 2013 with key staff across CQC. Some were staff who had been involved with the care home during its registration with CQC, or staff who were familiar with the processes and practices during the period. The group included staff who specialise in registration, compliance and safeguarding. The workshop was facilitated by staff on the investigation steering group and trained in root cause analysis techniques.

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459

