Hillcroft Carnforth Limited, Hillcroft Throstle Grove

October 2010 – January 2014

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

September 2014

Contents

Foreword

I was appalled by what happened at Hillcroft Throstle Grove and my thoughts remain with the people who suffered such awful care and with their families. We pay tribute to the courage of those who alerted ourselves and others to the poor care practices in the home.

The Learning Review commissioned by Lancashire Safeguarding Adults Board highlighted serious failings in the way the home was managed by Hillcroft Carnforth Limited between December 2010 and May 2012, but it also made recommendations for all agencies, including CQC.

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.

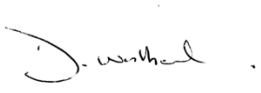
Our own review has identified a number of areas where we as an organisation can learn lessons. CQC check that people who use services are receiving safe, compassionate, high quality care and at times we missed opportunities to take action with this service.

The way we worked when these serious incidents happened meant we did not respond to early warning signs, we did not fully recognise the increasing risk to people using the service, and we were too easily reassured by the responses of the provider (Hillcroft Carnforth Limited) that they were able to improve.

Since then, a great deal of work has been done to drive forward significant and sustained improvements on many issues we identified as areas of concern – and we are changing for the better.

CQC is now more responsive to whistleblowing concerns and more effective in monitoring notifications of risk; our inspection techniques have improved with a greater focus on public involvement, and recruitment of additional staff is ongoing.

However, there is more we can and will do. We will keep working hard to make further improvements in partnership with people running care services, local authorities and other agencies to ensure that CQC does all it can to make sure Adult Social Care is the best it can be.



Deborah Westhead
Deputy Chief Inspector of Adult Social Care North Region
CQC
September 2014

Introduction

Hillcroft Nursing Home – Throstle Grove is a home in Lancaster and is a location of the organisation Hillcroft (Carnforth) Limited, which transitioned from the Care Standards Act 2000 to the Health and Social Care Act 2008 and was registered on the 1 October 2010. The nursing home provides care and nursing for up to 48 people who are elderly, frail, have nursing, dementia care needs or challenging behaviour.

Following an investigation by Lancashire Constabulary, which began in May 2012, four members of staff were charged with offences contrary to Section 44 of the Mental Capacity Act 2005, relating to mistreatment and neglect at Hillcroft Nursing Home, Throstle Grove. One member pleaded guilty in July 2013 and the remaining three members, who had pleaded not guilty, were found guilty at trial in November 2013 and sentenced in January 2014 for offences under section 44 of the Mental Capacity Act 2005.

Following a Learning Review in relation to Hillcroft Throstle Gove in Lancaster that was made public by Lancashire Safeguarding Adults Board in June 2014, we have published our own review.

This review sets out the actions taken by CQC, reviewing events leading up to the prosecutions and looks at points where CQC as the regulator could have done more to protect the people living at the home.

Summary of the sequence of events and CQC's actions

This is a review of the actions which the CQC took in response to the information it had at the time.

Hillcroft (Carnforth) Limited submitted its application for Hillcroft Nursing Home – Throstle Grove 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 and there was a registered manager in post. It was registered to provide care and nursing for 36 people. It was established at that time that the manager was not registered and the provider was informed that she was required to submit an application to register as the manager with CQC. The application was not submitted.

A scheduled inspection took place on the 5 July 2011; the report describes the home as being compliant with all the essential standards. Not all the standards were reviewed on site and outcomes relating to respecting and involving people who use services, the care and treatment of people who use services, the safety and suitability of the premises and staffing were reviewed and recorded as compliant.

Between December 2011 and March 2012 CQC received four whistleblowing contacts from anonymous persons working at the home, alleging ill treatment of residents, falsification of documents and claiming that no action was taken by the management at the nursing home when the issues were reported internally.

One of the contacts included the name of one staff member who later pleaded guilty to charges following the police investigation. The CQC inspector referred all the information to the safeguarding team and the contracts monitoring team at Lancashire County Council (LCC) the day following their receipt by CQC. CQC had not received any safeguarding notifications since registration from the location.

The LCC internal guidance at that time was that alerts without a named victim were the lead responsibility of the Adult Social Care Procurement Team (ASCP) because they had responsibility for monitoring the performance of services as opposed to dealing with individual issues.

In February 2012 the inspector made contact with LCC to request an update regarding the first two alerts that had been raised. The response from the council advised that the Hillcroft homes would be reviewed by the contracts team over the next few months and the Throstle Grove home in the next two weeks.

The inspector contacted the council in April 2012 for an update and was informed that the homes were still under review and there were serious concerns regarding the Throstle Grove home.

In April 2012, LCC contacted CQC to inform them that the contracts department were investigating Throstle Grove. Staff at the home had named three residents who were alleged victims of abuse. This had been referred to the safeguarding team.

In May 2012, a safeguarding strategy meeting was held and the following day a statement was received by LCC from the nominated individual of Hillcroft (Carnforth) Limited. The statement was from a cleaner at the home taken in September 2011 which suggested deliberate harm by a number of staff members. Lancashire Constabulary was informed and commenced an investigation at the home.

In May 2012 the Lancashire Constabulary removed a number of records from the home and the provider suspended five staff members and two managers working at the home. The focus of the police investigation centred on the challenging behaviour unit.

During the strategy meeting it was identified that the provider was operating another home which was not registered. The provider produced a registration certificate which included six locations. CQCs certificate recorded five locations registered. A request was made by the compliance inspector to the registration team to look into this further. This certificate was not an official certificate and appeared to have been 'doctored'. The directors of the company reported that the previous nominated individual, who had now left the company, had been responsible for this. As a result the local authority removed and relocated five people living at the unregistered location.

An application was received by the registration team on the 12 June 2012 to add one location to the registration of Hillcroft (Carnforth) Limited. Following assessment of the application, a site visit and a meeting with the provider the application was approved and the conditions to the registration varied to include the additional location.

CQC carried out a responsive inspection on 30 May 2012 to Hillcroft Nursing Home – Throstle Grove. The home was judged to be failing to comply with three standards of the six reviewed. The standards judged to be non-compliant with a moderate impact were safeguarding, supporting staff and assessing and monitoring the quality of service provision. Compliance actions were applied. The report excluded reference to allegations under investigation and was not published until July 2012 at the request of the police.

During this inspection it was identified that the number of people accommodated was 48 and the home conditions of registration identified a maximum of 36 people could be accommodated. The provider stated that the extension to the home was built in 2009 and additional people had been accommodated since that time. There was no evidence within the archive of ICAP that an application to increase capacity had been submitted.

An application was submitted to CQC on 4 September 2012 to vary the conditions of registration by increasing the numbers that could be accommodated from 36 to 48. Following a site visit on 17 September 2012 and after concluding that no enforcement action was currently being taken, the report was completed to approve the application and a new certificate was sent on 25 September 2012.

During June 2012 CQC carried out inspections to the other four registered locations of Hillcroft (Carnforth) Limited and judged all to be non-compliant in the standards relating to safeguarding and supporting staff with other areas of non-compliance at individual homes.

In May and June of 2012 CQC were aware of the ongoing police investigation. The LCC were also carrying out care reviews for everyone living at Hillcroft Nursing Home – Throstle Grove. The police took the lead role and used GOLD meetings to keep relevant agencies and family members updated. An operational improvement group was established in late June 2012 to lead multi-agency discussions with the provider to develop and implement an improvement plan.

In September 2012 a manager who was already registered with CQC as the manager of Hillcroft Nursing Homes North Road applied to CQC and was approved to take on the additional management responsibilities for Throstle Grove.

CQC carried out a follow up inspection on 9 and 10 October 2012 to monitor the compliance actions set following the inspection in May 2012. The home was judged to be failing to comply with all the compliance actions, with safeguarding judged as major impact, supporting staff minor impact and assessing and monitoring the quality of service provision moderate impact. A warning notice was served on the provider in respect of safeguarding as the home had not put sufficient control measures in place and compliance actions for the remaining two standards. It is noted that this report was mistakenly removed from the system. A separate process has recently been created in CRM where the information is held but the report is not on the CQC website. This issue is in the process of being resolved.

In October 2012 the home appeared on the North West Risk Register for the first time following the issue of the warning notice for breach of regulation 11. It remained on the register for three months. In December following a further review when the home was compliant the service was removed from the register.

A further inspection was carried out by CQC in December 2012 to monitor compliance with the warning notice and the compliance actions following the inspection in October and all the standards reviewed were met.

CQC carried out a scheduled inspection in September 2013 and all the standards reviewed were met.

Findings

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

1. The Transition Registration in October 2010.
2. In July 2011 an inspection at Hillcroft – Throstle Grove rated the standards reviewed as compliant.
3. CQC's management of whistleblowing concerns between December 2011 and March 2012.
4. CQC's collaboration with partners and its response to escalating concerns.
5. Variations to Registration.
6. Further inspections and management decisions.

1. The Transition Registration in October 2010

During this period the health and social care regulatory framework was replaced. All existing social care services were required to change their registration and the CQC to change its regulatory and enforcement policies and practices. The transition process was designed to complete the applications in a timely fashion due to the large number that required processing. As a result inspectors who processed the applications did not know the service and there was considerable pressure to complete the process quickly.

Hillcroft – Carnforth did not submit the transition application to register until 9 March 2011 despite several prompts by CQC to do so. On application they declared full compliance with all the regulations. Although they declared they had a registered manager in post at Throstle Grove it transpired that the manager was not registered and the provider was informed and a restrictive condition applied to the registration certificate at the time to require there to be a registered manager in the home by 31 May 2011. The registration certificate was sent out on 11 May 2011. The registration date on the certificate was 1 October 2010.

There were early warning signs at this stage in the reluctance of the provider to submit the transition application and their declaration that the manager was registered when they were not.

Causal factors in 2010/11

- The transition registration process was supported by staff that had little experience of the process.
- The timescales for completion of the transition registration were short and there was pressure to register services quickly.

Lessons learnt from this review

- The risks associated with periods of change, as with the replacement of the health and social care regulatory framework are high, and in such cases, it is important that knowledge is passed on and line management changes occur smoothly, with ownership retained until such time that the new manager has a clear understanding of any risks posed. During the current changes to the implementation of the new regulatory model a transformation team has been appointed to ensure that the transition to the new structure and model follows a logical process.
- Risks identified at the registration stage should be easily accessible for follow up by the inspection team.

2. The service inspection of Hillcroft – Throstle Grove in July 2011

The inspection was carried out as part of a routine schedule of planned reviews which took place on 5 July 2011, two months following registration. Four standards were reviewed and judged to be compliant. Feedback from relatives, people who used the service and staff was reported as positive.

However, safeguarding was not one of the standards reviewed at this inspection. Hillcroft – Carnforth group had not submitted any notifications to CQC from any locations in the group and although the provider had only been registered for two months the needs of the client group would indicate that this was unusual. It would appear that the issue relating to the unregistered manager was not raised at the time of the inspection or afterwards.

Causal factors in 2011/12

- There was a lack of an easily accessible overview of the history or escalating risk for each location and the quality and risk profile information at this time was limited.
- Inspectors were using a new IT system and had variable skills in negotiating the system to retrieve relevant information.
- The new inspection process was not embedded and there was a lack of clarity regarding the number of, and which standards, to inspect.
- There was a lack of clarity in CQC regarding the action to take when locations did not have a registered manager in post.
- Staff were under pressure to complete high numbers of inspections quickly which sometimes resulted in planning time being reduced.

Lessons learnt from this review

- If the history and escalating risk of the lack of notifications submitted by the provider had been readily available when planning the inspection it should have alerted CQC to test this at the time of the inspection.
- The absence of a registered manager should be easily identifiable on the IT system and Quality and Risk profile. The absence of a registered manager is known to have an impact on the quality of care and there were no systematic triggers to easily highlight this.
- There is a need to ensure that inspectors have adequate time to reflect and consider escalating concerns when planning an inspection.
- Wider inclusion of families and friends views about a service other than those who happen to be there at the time of the inspection would provide a more accurate reflection on whether the home is providing safe, effective, compassionate high quality care.
- Staff should receive adequate training and support to be confident to deliver what is expected in their role.

3. CQC's management of whistleblowing concerns between December 2011 and March

Between December 2011 and March 2012 CQC received information from four whistleblowing contacts who worked at the home but reported allegations anonymously. The first was in December 2011 which raised concerns regarding the ill treatment of residents by a named member of staff. The second contact was made in January 2012 which alleged the falsification of care documents, bullying by the matron and staff, and mistreatment of residents by taunting and swearing at them. The third contact was in March 2012 which alleged that four members of staff who were named were suspended and then reinstated following the abuse of residents, stating that the named members had stamped on a residents foot, pushed someone out of a wheelchair and beaten residents. Four days later a fourth contact was made with CQC which reported similar instances.

All the contacts were reported to LCC safeguarding team within one day of being received. CQC safeguarding records were created however the actions section of the records were incomplete. There was a clear pattern of concern being raised by the anonymous whistleblowers and combined these should have escalated the level of CQC's concern and prompted a management review meeting to discuss the escalating concerns. This did not happen and no action was taken by CQC at the time because it was felt that the LCC was carrying out a review of the service.

The combination of the concerns raised by whistleblowers and the lack of any notifications received from the home should have resulted in recognition of the escalated risk relating to the service.

Causal factors in 2011/12

- At the time there was a lack of easily accessible overview of the activity at the location and therefore escalating risk was harder to identify.
- New processes at the time were unfamiliar to staff.
- Staff were not familiar in the use of new policies regarding the regulatory responses to safeguarding alerts and concerns.
- Staff were inconsistent in the process to follow and regulatory response to whistleblowing concerns.
- There was a lack of understanding of CQCs role in partnership working with safeguarding, monitoring and commissioning teams in the local authority.

Lessons learnt from this review

- Inspection frequency decisions should be based on 'real time' information including safeguarding and other notifications, whistleblowing concerns and any other issues and there should be less reliance on judgements from previous inspections.
- Managerial oversight and supervision is important to ensure that escalating regulatory risks are acted upon in a timely way.
- CQC's whistleblowing and safeguarding systems should be monitored to ensure that the standards and expectations are applied consistently.
- It is important to consider provider performance and intelligence when registering additional locations or varying conditions.

4. CQC's collaboration with partners and its response to escalating concerns

Each time a whistleblowing concern was received, CQC alerted the safeguarding and contracts monitoring teams at LCC. There is no record of any conversations taking place between the council and CQC following the referral of the first two alerts. However in February 2012 the inspector made contact with the council and requested an update. CQC were informed that the Hillcroft – Carnforth group of homes were to be reviewed over the next few months with the Throstle Grove location being monitored within the next two weeks.

There is no record of any conversations occurring between CQC and LCC to discuss partnership working or CQC involvement despite an escalating picture of risk with a further two whistleblowing concerns received between February and March 2012.

CQC had not received any further information from the council and contacted them again for an update in April 2012 where it was reported that there were serious concerns about the location Throstle Grove and three residents had been identified at the home as alleged victims of abuse and the safeguarding team were investigating.

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

At this point it would have been expected that a Management Review Meeting took place to take stock of the evidence, discuss the escalating concerns and decide on the action to be taken. This did not happen.

A safeguarding strategy meeting was held and attended by CQC in May 2012. Following the disclosure made at this meeting by the NI, regarding information she had received in September 2011 from an employee working at the home which alleged abuse of residents, the Lancashire Constabulary investigated and subsequently suspended staff and removed documents from the home.

Following the police involvement the escalation of action from all partners involved was rapid and there was then engagement from all partner agencies, a willingness to share information and contribute to safeguarding meetings and later the GOLD meetings led by the police. However it appears that it took the police action to alert other partners to the seriousness of the concerns at the home.

Causal factors in 2011/12

- The CQC team did not understand the different roles of partner agencies and as a result there were variable responses to escalating concern.
- The relationship with the council did not encourage the sharing of information.
- Staff were not familiar in the use of new policies regarding the regulatory responses to safeguarding alerts and concerns.

Lessons learnt from this review

- Partnership working is essential and should be monitored. CQC should make clear with stakeholders their role and remit.
- The relationship management with the council should be strengthened in order to protect people who use services.
- Inspector and manager responsibilities should be strengthened in relation to conducting MRMs as part of escalating risk and not only post inspection.
- Staff should receive adequate training and support to be confident in carrying out their role.

5. Variations to registration

At the safeguarding strategy meeting in May 2012 it emerged that Hillcroft – Carnforth group were operating homes at six locations when they were only registered to operate from five. It transpired that the Nominated Individual (NI) had produced a fake registration certificate to include the location Hillcroft House which was not registered.

The provider submitted an application in June 2012 to add Hillcroft House as a location.

A site visit and a meeting with the provider was held and the registration team were satisfied with the providers explanation that they had been complacent relying on the NI, that they had appointed a new NI who understood the role and that the directors intended to have more involvement. The registration team acknowledged that this was not tried and tested.
The registration team had been informed by the compliance team of the concerns but at this time there had been no enforcement action taken against the provider. The decision was made to allow the variation to the registration as it could not be delayed on the basis that CQC had a duty to determine an application in a timely manner.

This was a serious breach of condition and the provider chose to open a new home without going through the registration process. This demonstrates a failure to understand the seriousness of the registration process and the need to protect the people living there. The provider's approval of the NI who went on to fake the registration certificate calls into question the provider's recruitment and selection procedures.

There was an opportunity for CQC to take action at this point; there was a breach of condition, an offence under section 33 of the Health and Social Care Act 2008 but there are no records to indicate that any MRM meetings were held in the registration team or the compliance team at the time to discuss the escalating risks or the breaches to condition.

CQC carried out a responsive inspection on 30 May 2012 where it emerged that the home were operating 48 beds when the condition of registration indicated the maximum number of people who could be accommodated was 36. The provider insisted that this had been the case since 2009 and in the absence of any historical information CQC were unable to ascertain if the provider had amended his registration prior to 2010.

The provider submitted an application on 4 September 2012 to increase the number of beds from 36 to 48. Following a site review the registration team checked with the compliance team that there was no prosecution pending and that there was no further action to be taken by the compliance team and the increase in beds was approved on 25 September 2012.

This was also a breach of condition and an offence under s33 of the HSCA 2008 but there is no escalation, management review meetings or discussions recorded and the focus appears to be on meeting the time frame for completion of the registration and the inability to refuse the application unless there is current enforcement action taking place.

Throstle Grove had been without a registered manager since the transition registration. A manager application was received in September 2012 and the application was approved. At the time the home was not compliant with three regulations and other homes in the group were non-compliant. The manager was registered to manage not only the Throstle Grove home but was also managing another home in the Carnforth group. This was described as a temporary measure but given the concerns across the Carnforth Group it is not clear why this was considered appropriate.

There were missed opportunities to take enforcement action and to consider the providers overall fitness at the point they applied to vary their conditions of registration on the basis of their disregard for the registration processes and unsuitable choice of NI. They were not complying with their existing conditions and so not fit to take on any more responsibility.

Causal factors 2012

- At the time CQC were inconsistent in the use of new policies and procedures relating to enforcement.
- Staff did not fully understand the actions they were able to take in relation to the breach of conditions.
- Timescales were short and inspectors were under pressure to register services as quickly as possible.
- Inspectors did not have time to plan the inspection and consider registration conditions prior to the inspection.

Lessons learnt from this review

- Staff should be able to pause and reflect when variations to registration are submitted to be able to take stock of escalating concerns.
- If the history of concerns about the provider had been fully understood, analysed and discussed at a Management Review Meeting it should have alerted staff to a provider who did not appreciate the seriousness of registration and conditions.
- Inspectors should have time to consider all elements of risk including conditions of registration when planning an inspection.

6. Further inspections and management decisions

Following the strategy meeting CQC carried out an inspection at the Throstle Grove home on the 30 May 2012.The home was judged to be failing to comply with three of the six standards reviewed relating to safeguarding, supporting staff and assessing and monitoring the quality of service provision with a moderate impact. Compliance actions were applied and the home submitted an action plan as to how they would comply with the regulations. This report excluded any reference to the police inquiry and was not published until July 2012 at the request of the police. This meant that people who used the service and members of the public were unaware of any concerns about the home.

During a follow up inspection in October 2012, which was carried out to monitor the improvements the home had made, CQC judged that the home had not improved the safeguarding arrangements at the home and the situation had deteriorated. The home was judged to be non-compliant with a major impact. Improvements were reported to have been made in the areas of supporting staff and assessing and monitoring the quality of service provision but the home was still non-complaint in these two areas, the former with a minor impact and the latter a moderate impact.

A Management Review Meeting was held following the inspection to discuss the planned action. However the documented information in the review record is minimal and does not describe the discussion that took place or how the decisions for action were arrived at. There was no record setting out the reasoning as to why more urgent regulatory action wasn't taken. The element to consider other options was blank in the review record. There was no discussion regarding the ongoing police inquiry or how this may impact on the people who used the service or staff.

The decision was made to issue a warning notice for a breach of regulation 11 safeguarding and further compliance actions in relation to supporting staff and assessing and monitoring the quality of service provision, despite this having been judged as a moderate impact, the same as at the previous inspection in May.

The regulatory process within CRM for this inspection was inadvertently deleted and the report was never published. The warning notice was served, however the public and people who used the service were unaware of the continuing issues at the Throstle Grove home. A separate process has recently been created in CRM where the information is held but the report is not on the CQC website. This issue is in the process of being resolved.

Following the inspection in October 2012 the home was logged on the North West Risk Register and described as major concern/ major impact / low risk. The register details the concerns regarding the information received from whistleblowers, the police investigation and current breaches to the regulations. It remained on the register for three months until December 2012 when the follow up inspection had been completed and the home was found to be compliant.

At this time the terms of reference and criteria for escalation to the register was followed when the home was issued a warning notice. However the history of concern that this service presented raises questions around the criteria for inclusion on the register.

Inspections were carried out in December 2012 and September 2013 and at both inspections all the standards reviewed were met demonstrating an improving picture of compliance.

Causal factors 2012/13

- Staff were under pressure to complete high numbers of inspections which sometimes meant planning time was reduced and follow up inspections delayed.
- During the period of review there was a change of manager three times and inspector once.
- There was a general lack of investigative skills to expand the scope of the inspection to follow up concerns and risk.
- The process for holding Management Review Meetings were often rushed with pressure to make quick decisions, without the time to reflect, together with poor recording of the process.

Lessons learnt from this review

- Managerial oversight and supervision of inspectors is important and must be maintained to ensure escalating risks are acted upon.
- Management Review Meetings must be accurately recorded and include the reflection of the concerns, analysis of the information considered in the decision making process and the rationale for the course of action taken.
- The CRM system should be reviewed to ensure the loss of regulatory information does not happen in the future. The publication of reports is vital in helping families make choices about care provision.
- The inclusion of an expert on the inspection team is vital when there are specific areas of concern.
- Wider inclusion of families and friends views about a service other than those who happen to be there at the time of the inspection would provide a more accurate reflection on whether the home is providing safe, effective, compassionate, high quality care.

Conclusion

The analysis of CQC's actions in relation to the regulation of Throstle Grove has identified a number of areas where we as an organisation can learn lessons. CQC check that people who use services are receiving safe, compassionate, high quality care and at times we missed opportunities to take action with this service.

Changes since 2011/12 mean that CQC is now more responsive to whistleblowing concerns and in monitoring notifications. Our approach to inspection is fundamentally different and recruitment of additional staff is ongoing.

During the course of this review we spoke with a family member to gain their views on the actions CQC took during the course of the events which occurred at Throstle Grove. They offered some helpful information which should be considered as CQC moves forward.

- Information should be sought from family members and those who use the service prior to the inspection and not at the home. There may be a reluctance to provide information on site because of the potential fear of the outcome of providing negative comments.
- There was concern as to why it had taken CQC so long to address the lack of a registered manager at the home.
- There was a perception that the provider was more likely to improve the service if there was a financial penalty to not meeting the regulations.
- There was concern that retrospective action could not be taken when breaches to the regulations became known.
- Any action taken against a provider should be in the public domain.
- Inspection reports should include specific findings particularly when improvements are required. The reports are viewed as too generalised and standardised.
- There was a perception that the comments used in the service user's views section were not real, as many reports included the same comments and focussed too much on positive information. At the present time the reports do not add to an understanding of how well the home provides safe, compassionate, high quality care.

While there is ongoing improvement at CQC we must remain aware that as the transformation programme continues we are vigilant to the potential loss of information, the improvements we need to make to our information systems and the training and recruitment of our workforce.

The review identified that at the time we did not recognise the increasing risk at the service and we must ensure that in the future this triggers the necessary responsive action. Managerial oversight is crucial.

There is little evidence that we worked collaboratively with partner agencies until such time as the police escalated the concern and suspended staff. Collaboration is essential both internally and with external partners, and at key points collaboration did not happen.

We were too easily persuaded by the provider's reassurance that they were able to improve and provide people with safe, effective, compassionate, high quality care at each stage from the transition registration through to the applications to vary their registration and the appointment of a registered manager.

There is little evidence that CQC regularly reviewed all the information held about Throstle Grove or the provider, and this included points when the management oversight changed.

At the time, registration and compliance inspectors were under pressure to register services in a timely way and inspectors had high numbers of inspections to complete.

Hillcroft Throstle Grove demonstrated an improving picture of complying with regulation from December 2012 to January 2014. However, given the providers history it will be important to monitor if this is sustainable at not only the home itself, but within the Carnforth Group as a whole, so that any escalating risks are identified and responded to promptly.

Appendix: Investigation terms of reference – Hillcroft Nursing Home, Throstle Grove

Purpose

To identify the key points, where an opportunity existed, to take alternative action relating to Hillcroft Nursing Home Throstle Grove, from transition registration with CQC to January 2014. 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 period from registration with CQC of Hillcroft Nursing Home Throstle Grove to January 2014.
- 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.
- To provide a report and record of the process and outcome.

The review will be led by the Quality Risk Assurance Manager. 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.

Methodology

As part of the review of events, the Quality Risk Assurance Manager will review evidence collected from staff, the CQC internal database, and the chronology of events spanning the period October 2010 to January 2014.

- ICAP and CRM records relating to Hillcroft Nursing Home Throstle Grove including all safeguarding, notifications and inspection activities.

- CQC Registration report for Hillcroft Nursing Home Throstle Grove.
- CQC Management Review Meeting records.
- CQC Inspection reports for Hillcroft Nursing Home Throstle Grove.
- Judgement Framework CQC Guidance about compliance – Published March 2010.
- Setting the Bar: Monitoring of Compliance CQC Guidance for Inspectors – Published September 2010.
- CQC Safeguarding Protocol – Published June 2010.
- CQC Safeguarding Protocol – Published April 2012.

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How to contact us

Call us on: **03000 616161**

Email us at: **enquiries@cqc.org.uk**

Look at our website: **www.cqc.org.uk**

Write to us at: **Care Quality Commission**
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Follow us on Twitter: **@CareQualityComm**

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