**Review touching upon events at**

**Lake and Orchard Care Home Selby**

**Between January 2020 and August 2020**

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|  | **Introduction** |
| 1. | I was requested by NHS Vale of York CCG and North Yorkshire County Council supported by partners to review the involvement of public bodies and organisations in the work of the care home, Lake and Orchard, in Selby. This request was following the cessation of services out of these premises in August 2020. |
| 2. | I am employed by NHS Vale of York CCG as the Head of Legal and Governance and I am a qualified lawyer by training. I was not involved in any decision making about Lake and Orchard at any time and I am not line managed by any of the individuals involved in the closure of Lake and Orchard. I am an Assistant Coroner in England and therefore have a particular skill set associated with reviewing large amounts of complex and sensitive information and reaching conclusions on the basis of that evidence. It was on this basis that I was asked to undertake this review.  |
| 3. | The review was to look at learning from the experience as well as to highlight good practice where that was evidenced. It was to see whether or not there were earlier opportunities to intervene in the home and support those residents and staff. |
| 4. | I was specifically asked to look at three periods of time:-1. 1 January 2020 to 23 March 2020
2. 24 March 2020 to 30 July 2020
3. 31 July 2020 to 28 August 2020

I was also asked to look back at the organisational context of the home back to 2017 from a regulatory perspective and CQC and NYCC safeguarding teams have been supportive in providing me with information related to this.  |
| 5. | I have not been asked to, and I have not, contacted the provider of services at Lake and Orchard to comment upon this review as the focus of my review was around the involvement of:-1. NHS Vale of York CCG
2. North Yorkshire County Council Health and Adult Services (NYCC 'HAS')
3. Community Services provided by York and Scarborough Teaching Hospitals NHS Foundation Trust
4. Care Quality Commission
5. Primary Care
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| 6. | I have reviewed a number of documents including CQC reports, collective care minutes, safeguarding reports and the Safeguarding Policy 2018 which would be the applicable policy for the period reviewed. I have also had the opportunity to speak to a number of individuals involved in Lake and Orchard. All those I spoke to were open, honest and wanted to learn the lessons from the experience at Lake and Orchard. |
|  | **Impact** |
| 7. | I was struck, in the course of this investigation, at just how affected those I spoke to were about what they had witnessed at Lake and Orchard. The initial report for the first visit to the home describes inadequate adherence to IPC practices, not just for the prevention of Covid-19 but general hand washing at meal times was not followed for example. Whole home testing for Covid-19 had not been done by 9 August 2020. Residents were described as dirty, with the remnants of breakfast still on their clothing at lunch time. They were described as thirsty and hungry as staff were not dedicating time to support them with nutrition.  |
| 8. | Nutrition and hydration were not adequately recorded and there was poor positioning of residents who spent large periods of time, unseen, unheard and not monitored in their bedrooms. All of this meant that most residents seen had skin damage. |
| 9. | I was struck by an email which was sent from one of the CCG nurses who had visited the Home on 9 August 2020 in which she stated 'significant issues with Lake and Orchard.' 'The worst we have yet seen.' 'Seasoned social workers are upset by what we have found'.  |
| 10. | The emotional impact on the staff supporting the residents to leave this home should not be underestimated not to mention the impact upon the residents themselves and their families. |
| 11. | During the course of moving residents, the rooms were found to be squalid and old food was found in rooms. As peoples possessions were identified to move with them it became clear that there were items retained in the Company safe that belonged to residents who were deceased. |
| 12. | The impact on residents of moving was something that was of concern however there were some really positive examples on residents after their move. All residents were followed up in the days after the move and most were well and happy following the move. One particular story that resonated with me was of one lady who had been put in the bath in her new placement for the first time in months and although the bath water was filthy afterwards she had really benefitted from that personally and was really happy in her new placement. Almost all those that were followed up on were reported to be eating and drinking well, gaining weight and having medication reviews.  |
|  | **Chronology** |
| 13. | Lake and Orchard was inspected in January 2017 when it was owned by Embrace (South West) Limited. The overall rating for the service at that time was 'requires improvement' and this included a rating of 'requires improvement' for both the 'safe' and 'well led' domains of inspection. Sanctuary Care (South West) Limited took over the home in June 2017. |
| 14. | Lake and Orchard has been in Collective Care since at least May 2018. Collective Care is a process which is led by the Local Authority to support challenged providers of services to improve, seek support and input and to ensure the safety and wellbeing of the residents and staff supported by those services. It is intended to be a safe space where concerns can be raised and resolutions can be agreed. The Local Authority Chair the Collective Care meeting and it is attended by the Provider, partners agencies including Health and Social Care and where appropriate CQC. The intention of Collective Care is to wrap a team of support around the provider to prevent failure of that provider. This should not be a long term requirement.  |
| 15. | There was a further CQC inspection in March 2018 which appeared to show a decline in the quality of services with the 'well led' domain being rated inadequate however the overall rating remained 'requires improvement' |
| 16. | In April 2018 there was a multi-agency safeguarding policy approved which made amendments to the way in which safeguarding concerns would be approached by all agencies involved in these incidents.  |
| 17. | On 25 July 2018 there was a collective care meeting which took place. |
| 18. | On 14 September 2018 there was a collective care meeting which took place. |
| 19. | On 5 December 2018 there was a collective care meeting which took place. |
| 20. | A re-inspection of the service took place in December 2018 and improvements had been made in four domains from the inspection in March 2018. Overall the service remained 'requires improvement' however there were now 'good' ratings in the 'effective', 'caring' and 'responsive' domains with 'require improvement' in all of the other domains. This was also the first inspection which did not demonstrate any breaches in Regulations and this appears to have reset the approach which CQC took in terms of the inspection regime.  |
| 21. | On 22 February 2019 there was a collective care meeting which took place. |
| 22. | On 18 April 2019 there was an internal NYCC HAS concerns review meeting. |
| 23. | On 10 May 2019 there was a collective care meeting which took place.  |
| 24. | On 2 July 2019 there was a multi-agency Professionals meeting which took place. This included CQC, NYCC and safeguarding personnel from health. |
| 25. | On 16 August 2019 there was a collective care meeting held for Lake and Orchard. At this meeting it was concluded that Lake and Orchard care home could come out of the collective care process. |
| 26. | On 10 September 2019 there was a further collective care meeting for Lake and Orchard where it was apparent that significant concerns were escalating again and the home was returned to the collective care process. |
| 27. | On 9 December 2019 there was a further collective care meeting. |
| 28. | January 2020 saw the home re inspected by CQC and this resulted in a further 'requires improvement' rating although overall this was a reduction in rating as there was a decline in the ratings for 'effective', 'caring', 'responsive' and 'well led'.  |
| 29. | On 18 January 2020 resident A was admitted to hospital following an unwitnessed fall. The provider would be required to notify the Regulator of falls where such an injury is sustained. It is not clear whether this was done in this case. The resident suffered a fractured wrist, fractured neck of femur and humerus. There were safeguarding concerns raised as part of this admission.  |
| 30. | On 27 January 2020 resident B was admitted to hospital following a fall out of bed and sustained a fractured neck of femur. This was not coded in the Emergency Department as a safeguarding concern and therefore there was no review by the safeguarding team. |
| 31. | On 19 February 2020 resident C was admitted to hospital when Lake and Orchard reported they were not coping with them. This was not coded as a safeguarding concern by the hospital and there was no review by the safeguarding team. From the information available to me at the time of the review I am unclear as to whether there was a requirement for safeguarding input from this admission. |
| 32. | On 24 February 2020 resident D was admitted to hospital following an unwitnessed fall resulting in a large parietal haematoma. Again, this was not coded as a safeguarding concern by the hospital and therefore there was no review by the safeguarding team.  |
| 33. | On 26 February 2020 resident A was readmitted to hospital (having been discharged on 6 February 2020) with an acute kidney injury which most likely was related to dehydration. It is not clear whether this was recorded as a safeguarding concern.  |
| 34. | On 19 March 2020 national guidance was issued to Community Providers about prioritisation of community health services which led to Community Services being reviewed in the way that they worked during the early stages of the pandemic. The Community Provider in this case was York and Scarborough Teaching Hospitals NHS Foundation Trust |
| 35. | On 23 March 2020 the Country went into the first national lockdown. Face to face visits were limited and many care homes declined to admit professionals who would ordinarily visit residents. Lake and Orchard did not refuse admission to community nurses or other therapists. |
| 36. | On 4 April 2020 resident E was admitted to hospital with aspiration pneumonia. |
| 37. | On 17 April 2020 resident F was admitted to hospital with a urinary tract infection and delirium as Lake and Orchard could not get the resident to take antibiotics. It was recorded that the resident was resistant to support.  |
| 38. | On 31 July 2020 resident C was readmitted to hospital with a head injury as a result of a fall. It is not clear whether this was recorded as a safeguarding concern.  |
| 39. | On 27 July 2020 there was an internal NYCC HAS concerns review meeting held. |
| 40. | On 30 July 2020 there was a multi-agency professionals meeting held. |
| 41. | In July 2020, during the Covid-19 pandemic the service was partially inspected by CQC who completed a focused review in the domains of 'safe' and 'well led' and these were both inadequate resulting in an inadequate rating overall.  |
| 42. | On 3 August 2020 there was a multi-agency risk meeting which commenced every other day increasing to daily until the point of the home closure. |
| 42. | During the multi-agency risk meeting it became clear that NYCC and the CCG were of the view that more robust action was required to safeguard those residents at Lake and Orchard. The Regulator was undertaking a process of review and as a result the Public Bodies involved took a decision to remove the residents of the nursing unit from Lake and Orchard for their own wellbeing. As a result of this the Regulator took a decision that a Notice of Decision could not be issued because the risk had been removed as a result of the decision by Partners. This was a source of frustration for the public bodies who had taken a decision to reduce risk to individuals and were then seemingly penalised for it.  |
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|  | **Findings** |
| 1. | There was an over reliance placed on the provider describing minor improvements in overall care quality resulting in a de escalation in the surveillance around this provider prematurely and without evidence that what partners were being told was both accurate and sustainable. |
|  | Lake and Orchard Care Home were in collective care for a considerable period of time prior to closure. They had also been removed from the collective care process on 16 August 2019 only to be returned to collective care on 10 September 2019.  |
|  | It appears that the basis for the removal from collective care on the 16 August 2019 was that the Home Manager had indicated staffing levels had improved and appear to point towards the previous deputy manager being culpable for the underperformance previously.  |
|  | There is reference in the minutes to the new Deputy Manager being a very strong leader. But there is also some cause for concern that the Home Manager will be managing the residential side while the Deputy Manager is on leave as there was no-one else suitable and this was possible because of the recruitment of a new manager. There is a comment from the Chair that 'he found that slightly concerning but he did not want to question capability'. It was entirely appropriate for the Chair to question capability given the position the Home found themselves in.  |
|  | The rationale for removing the Home from collective care was that 'the risk appeared further reduced and that improvements were evident and ongoing.' There was clarity that staffing levels had improved and that the 'Home was performing well and although the Home had a history of challenges there was also a history of resolving those challenges'. |
|  | Whist it is clear that there are improvements described in the minutes, there is not adequate evidence to suggest that these will be sustained at the time the collective care process is stood down. This is also the case based on the organisational context at that time. This is supported by the catalogue of issues reported in the September meeting including a question over whether information is being reported to the CQC and the Local Authority from the Home. |
|  | In December 2018 CQC carried out an inspection of Lake and Orchard Home. This gave an overall rating of 'Requires Improvement' and is against the background of two earlier inspections also being 'Requires Improvement' overall.  |
|  | This inspection however did rate three areas as good which was an improvement on the picture previously. Concerningly however, the domains of 'Safe' and 'Well-Led' remained 'Requires Improvement' and yet this appeared to be seen by CQC as a 'break' or 'reset' in terms of their approach to the Home.  |
|  | Reviewing the wording of the report at page 8 from this inspection there is reference to 'During our inspection there were sufficient staff on duty, but they were not always effectively organised and deployed on Orchard unit. Staff were very busy, particularly at mealtimes, and this impacted on the quality of care people received. We spoke with the manager about improving the supervision, co-ordination and leadership of staff during mealtimes and at busy periods. This was important to make sure people were not left unsupervised in communal areas and staff were available to provide attentive support when needed. The manager told us they were looking at whether 'kitchen assistants' could help during mealtimes so care staff had more time to support people.'There is also reference at page 9 to 'They showed staff used nationally recognised tools, such as the Malnutrition Universal Screening Tool, to assess the level of risk and to make sure appropriate control measures were in place to help keep people safe' It would appear that the link between the concerns identified in staffing during mealtimes and the positive use of the malnutrition tool have not been sufficiently balanced to understand the impact of having a tool which is not supported by practice.  |
|  | This report has been a trigger for a more assured approach being taken, by the Regulator, towards this provider. The report summary states at page 3 'The overall rating for this service is 'requires improvement'. Whilst this is the sixth consecutive time the service has been rated inadequate or requires improvement overall, the continued improvements and trajectory showed positive leadership. The provider had made significant progress since the last inspection and was now compliant with the fundamental standards of quality and safety. This progress demonstrated an ability and ongoing commitment to improving the service. We will continue to work with the provider to monitor progress and support improvement to achieve at least a good rating overall.' |
|  | 13 months then passes until the next inspection which takes place in January 2020. This report states 'People did not receive good quality care. The provider had failed to make improvements and act on recommendations made by professionals following the last inspection. We met with the provider during this inspection to outline the improvements required and to seek assurances of their commitment to making improvements at this service.' |
|  | It goes on to say 'the last rating for this service was requires improvement. The service remains rated requires improvement. This service has been rated requires improvement for the last seven consecutive inspections.' |
|  | There were a number of breaches of Regulations identified and specific steps which needed to be taken at page 17 of the report.  |
|  | It is not unreasonable that CQC took a view that the picture was improving at Lake and Orchard in December 2018 however the organisational context ought not to be lost. This is demonstrated in the fact that the following inspection identified significant breaches in Regulation. |
|  | It is not clear to me how CQC worked with the provider following the inspection in 2018 or whether there were reviews about how effective this work was given that the picture has deteriorated following this inspection rather than improved.  |
| 2. | There appears to have been a de escalation in organisational risk profile without adequate risk assessment from all public bodies involved. |
|  | The pandemic took hold of the UK in February 2020 and resulted in a national lockdown on 23 March 2020. Organisations were required to understand the risk profile of Care Homes to decide how to support them. It was identified by the Community Nursing Team at York and Scarborough NHS Foundation Trust, and the CCG, that some Care Homes were not allowing access to staff during the pandemic. It appears, from discussion with the Local Authority and CQC, that the fact that Lake and Orchard did allow access to the premises, was seen as a significant safeguard and lowered the risk profile of the organisation at the start of the pandemic reducing the likelihood of anyone setting foot in the Home during the pandemic.  |
|  | Further, the fact that the provider had recently had to evacuate all residents during a flooding episode and had done so well, was seen as a significant safeguard in terms of demonstrable leadership. Again, this influenced the risk profile at the commencement of the pandemic and decisions about whether individuals could go into the Home during the pandemic.  |
|  | Primary Care describe having concerns about Lake and Orchard for many years prior to the Pandemic. These do not appear to have changed the view of primary care about the way in which they carried out their 'ward rounds' during lockdown and were not formally raised as safeguarding concerns that I can find documented. The CCGs provided all care Homes with technology to ensure that video consultations could take place and it was not raised with the CCG that Lake and Orchard were not doing that until the closure in August 2020 when the ipad was found unopened.  |
|  | If professionals were aware of concerns about Lake and Orchard prior to the national lockdown, it appears that these were not triangulated and they were not factored into decision making at the start of the pandemic. I cannot see any clear rationale for an organisation which had seven consecutive CQC inspections with a rating of 'requires improvement' at best; where the Local Authority had awareness that this provider was in collective care and had been for a significant period of time; where primary care had concerns about the quality of the service this provider delivered and where there were safeguarding concerns about this provider; to be seen as anything other than a high risk care provider as the country went into lockdown and why a programme of visibility checks was not planned around the residents living there.  |
| 3. | Neither the CCG or the Local Authority had clear escalation parameters in place that would ensure senior oversight of the provider at an earlier stage. This may well have led to an earlier resolution of the issues involved in this case. |
|  | In speaking to the Chief Nurse for the CCG and the Assistant Director Adult Social CareIt is clear that it may have been beneficial for the full picture of the concerns at Lake and Orchard, to have been known and understood by Senior members of the Local Authority and the CCG earlier. Whilst there is a requirement to trust the professional skill set of those involved in safeguarding and adult social care; it would also be helpful to them to understand at what point they should escalate concerns through the organisation. Effectively this would be a description of organisational risk tolerance for these concerns. This would also alleviate some of the concerns referred to in finding number 8. |
| 4. | The co-ordinated processes that were overseeing Lake and Orchard Care home were not based on adequate and complete risk assessments. |
|  | Although those responsible for reviewing Lake and Orchard in collective care and under the CQC Regulatory framework were collaborative and CQC attended the collective care meetings; there is no sense that information from one partner triggered a reaction in another.  |
|  | The decisions taken in collective care are based on information provided in those meetings. There is no risk framework described or talked about and there is no discussion about how the experience is for service users in the service (accepting that individual safeguarding concerns are referred to during the meeting).  |
|  | It is hard to see how the decisions made in the August 2019 meeting to remove Lake and Orchard from the collective care process are robust when less than a month later the Home is back in collective care with very serious concerns raised about the safety of service users and safeguarding concerns. I am unclear what information was actually available in the August meeting that may have led to a different outcome. However, what is clear is that the service that is described in the September 2019 meeting has not developed over the course of one month, this has been some time in the making and not acted upon swiftly. |
| 5. | Actions in collective care meetings and safeguarding investigations had no sense of urgency with the date set for completion as 'A.S.A.P' in most cases.  |
|  | Throughout the minuted records for the collective care meetings and safeguarding investigations action deadlines are routinely set as 'A.S.A.P'. This does not give the appropriate sense of urgency or progress in these matters and is open to significantly different interpretation. For one individual, receiving an action out of this meeting that needs to be done ASAP may mean it must be done within 24 hours, for another it may mean when they return from annual leave in three weeks’ time.  |
|  | The person chairing the meeting needs to set a date by which the action must be undertaken. This would ensure that other people take the actions on in the event of an absence and would also give the required sense of urgency to the improvement programme. Where actions were listed as requiring action 'ASAP' these did not seem to be followed up at the next meetings or escalated if not done and therefore ASAP seemed to not result in resolution in any cases.  |
| 6. | Safeguarding investigation outcomes were, on occasion, based on inappropriate evidence or inappropriate thresholds. The teams involved in the investigations do not appear to be able to readily identify the expert advice that is needed for the proper resolution of those investigations; or neutrally balance evidence available. |
|  | In order to reach this finding it is important to note that I have undertaken a deep dive into a select few Safeguarding cases. I was able to select the cases I wanted to review myself from the summary of each of them and was provided with all documentation related to that individual case for review. |
|  | From reviewing the minutes of the safeguarding strategy meetings I can see evidence of challenge from the Chair routinely and an appropriate steer from the Chair about the standard of proof required for the allegations to be made out.  |
|  | I have been made aware since the Lake and Orchard safeguarding cases were raised, that the process for safeguarding has changed and it is no longer the case that allegations are 'substantiated' or 'not substantiated'. Whilst this is helpful in terms of making safeguarding person centred, it is potentially going to be a challenge unless those managing the incidents are adequately aware of and trained on investigations, evidence and legal weighting.  |
|  | I will not provide individual detail of the safeguarding allegations in this report however I can do so if required in an appropriate forum and with the appropriate anonymisation in place. To support the finding above however I will note the following: |
|  | * One allegation related to skin integrity and tissue viability. Advice was sought from the GP as part of the safeguarding investigation who advised there were no concerns. Plainly there are two issues with this, the GP either was not aware of the full circumstances of the incident or the circumstances were disregarded for the purposes if the incident and secondly, more specialist advice on skin integrity issues should be sought from nursing staff with expertise in tissue viability. Primary care are excellent generalists and advice should absolutely be sought on the overall clinical picture of patients however for this sort of investigation, it is vital that the right expert is identified.
* There was an allegation made by an individual (a resident in this case) who clearly had made allegations previously. This was a strong factor used against finding the allegation substantiated and, on review, I believe inappropriately swayed the investigation team.
* It appears that there was an inbuilt view that if someone had complained previously, whether that was a resident, staff or other visitor, any future complaints were treated with less weight than new complaints.
* There was little demonstrable evidence of those without mental capacity being supported to engage in the process. Instead decisions are made on their behalf with no reference back to them or any views that they have been able to express. This included a failure to recognise the emotional and psychological impact some of these incidents will have had on individuals notwithstanding their capacitous status.
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| 7. | Risk assessments conducted during the safeguarding investigations were not evidence based and therefore would not be robust and objective.  |
|  | Risk assessments recorded in the safeguarding incidents I reviewed had the sense of assumption or perception and were not evidence based. The risk assessments risked being subjective with no clear rationale. They were not based on a shared understanding of risk appetite or what was tolerable either to organisations or the Safeguarding Board.  |
|  | Again, where individuals did not have capacity they were not involved in the risk assessment. Equally the fact that they did not have capacity, which increases their personal vulnerability, was not considered routinely. |
|  | Assessments were often based on actions which were not part of the safeguarding process. For example, the risk had been removed because an individual had left the organisation. Safeguarding is about protecting vulnerable people generally not just specific named individuals. It is highly likely that if an individual leaves an organisation, they will simply move to a different one caring for equally vulnerable individuals. It is important that safeguarding processes are completed to prevent harm to individuals in those other placements. Reference is made to referrals to DBS, almost as a point of reassurance. Having an understanding of the DBS process; the quality of the safeguarding investigations and the evidence gathered as a result is unlikely to support a disclosure being in the public interest. As a result a referral to DBS in these cases is of no reassurance.  |
| 8. | As this provider had been on the radar of organisations for such a long period of time, there is evidence that de-sensitisation had set in with public bodies which potentially meant that poor quality was tolerated for longer than it ought to be.  |
|  | The evidence referred to above supports this finding. CQC had tolerated 7 inspections of requirements improvement with little sign of improvement other than a to-ing and fro-ing about breaches of Regulations.  |
|  | Likewise the collective care process had inadequate deadlines and a high tolerance for continued provider failure.  |
| 9. | Build a collective understanding of what practice is acceptable and what standard is tolerable in placements. 'Making Every Contact Count' |
|  | During the review into the events at Lake and Orchard. It became apparent that a number of people made comments such as 'it's always been like that' or 'that's just Lake and Orchard'. There was also a question that clinicians who had previously been in the home acknowledged there had been poor practice there for 'around 20 years'.  |
|  | It is unclear to me, from speaking to individuals with some corporate history with Lake and Orchard whether their standards simply became lowered as a result of time and no significant improvement; whether they initially raised concerns which were not dealt with in a robust way; or whether there was a view that it was someone elses responsibility. Whatever the reason the outcome remains that residents, many of whom were unable to advocate for themselves, lost out on an opportunity to have professionals advocate for them.  |
|  | The District Nursing and community teams were asked about their recollection of the standard of hygiene as part of the review. The only teams who had been into Lake and Orchard face to face during the pandemic were the Community District Nursing Teams. All other contacts were virtual. The Community District Nursing Team were unable to recall specifically any particular issues in Lake and Orchard however given the experience of other staff who visited the home it is unlikely that there were no issues evident when the home was visited by the District Nursing Teams going into Lake and Orchard. It is possible that they were not noted because of the time pressures as a result of the pandemic and also the need to confine visits to specific residents however it may have been that opportunities to note conditions earlier were missed. I was not able to obtain specific evidence either way on this position however.  |
| 10. | CQC had evidence of potential harm from inspections that had been conducted prior to July 2020 however this appears to not have been appreciated as readily as when they were supported by clinicians and social care staff in the final inspection. CQC should consider whether they require additional support when undertaking an inspection of a provider who has been underperforming for 2 or more inspections. |
|  | When the CCG and Local Authority team went into the home in July and August 2020 the primary areas of concern were all inextricably linked. Hydration, nutrition, skin integrity and IPC practices. For the avoidance of doubt, it has long been established that there is a link between good nutrition and good hydration and fewer issues with skin integrity. This does not mean that those with good hydration and nutrition will not suffer from skin integrity issues, but it is a supportive measure to prevent extreme skin integrity issues and importantly promote healing.  |
|  | Likewise, IPC practice is vitally important where there are challenges with skin integrity, to reduce the likelihood of infection. I need not comment on the heightened importance of good IPC practices in the midst of a global pandemic.  |
|  | Certainly, in the June 2018 inspection it was clear that there were issues with a person not being offered alternative food provision when they refused the options presented. There was also recorded at this inspection that a person had skin integrity issues but the skin integrity care plan recorded their skin was intact and did not include information about the involvement of the district nurses. |
|  | In February 2019 there was reference to the availability of provision of sufficient staff to people, particularly at mealtimes and this impacting on the quality of care. The manager had indicated that they were looking at whether 'kitchen assistants' could help during mealtimes so care staff had more time to support people. Again, this is relevant to nutrition. There is also reference to 'at mealtimes on Orchard, staff lacked leadership and direction' |
|  | In the Inspection on 16 March 2020 there was reference to 'the environment had not always been properly cleaned and maintained to keep people safe and prevent infection. Care records did not always show checks, including pressure area check, had been completed to evidence people's care needs were being met.' |
|  | In the Inspection on 19 August 2020 the inspection was triggered, in part, due to concerns received about the management of people's pressure areas, catheter care, medicines and care needs. These concerns, particularly around pressure area management, were present during the inspection in March 2020.  |
|  | It is of note that the safeguarding concerns and the collective care process also included these concerns and CQC were invited to or were represented at these meetings.  |
| 11. | Safeguarding investigations were not robust and timely and therefore potentially missed opportunities to safeguard others from harm. |
|  | I am not clear from reading the notes how the safeguarding investigations have concluded and I am aware that some remain open almost a year after the event.  |
|  | When I spoke to representatives from primary care they were keen to be far more involved in safeguarding than they currently are, accepting that it is difficult to do so in the context of their time commitments. They would value alerts about services in their area or their individual patients which would make them more risk focussed in their approach to reviewing those patients. In the context of primary care 'ward rounds' and a named clinician for each home was instigated by Covid-19. This was part of the Nationally required response to the pandemic and a new primary care contract was issued as a result. This should have meant that primary care were better able to identify at risk individuals and see them virtually, ideally through video conferencing but at the least through telephone triage. In the case of Lake and Orchard video conferencing was not done and not something which Primary Care requested, instead speaking to the nurse on the nursing unit. A further risk was that the collective care process lines and the safeguarding process lines at Lake and Orchard had, for some time, been blurred. The safeguarding incidents were closed as collective care was seen to be managing the concerns however that is not the purpose of collective care. Primary care are not represented at collective care and therefore an opportunity for GPs particularly, to seek assurance about particular at risk individuals, was lost. |
| 12. | There was an immature (within the remit of safeguarding) approach to the Mental Capacity Act demonstrated in the safeguarding investigation reports which does not appear to consider the full circumstances of the cases. |
|  | Safeguarding investigations appear to make assumptions on Ps behalf without an evidential basis for that. For example in a number of the safeguarding investigations that I reviewed, there was reference to P not being able to express a view about what they wanted as an outcome because they did not have capacity. I was not assured that the principals of the Mental Capacity Act had been properly applied to this decision and equally, if they could not express a view, there was no suggestion of an outcome that might be in their best interests.  |
| 13. | The safeguarding investigations did not base their findings on appropriate evidence or the correct standard of proof. |
|  | The standard of proof in a safeguarding investigation is the balance of probabilities. Whilst I know that the policy has changed to a point where safeguarding cases are no longer substantiated or not, there will still need to be an assessment of the evidence to establish whether harm has been caused or may be caused. This should be done by weighing the evidence available (with an understanding of what category evidence falls into) and assessing it against the correct standard of proof. |
|  | Evidence comes in many forms and this needs to be properly understood by those investigating. For example, understanding who the correct expert is in a particular case; for example, a GP is not an expert in tissue viability therefore where tissue viability is an issue in a particular case, I would expect reference to be made to the relevant expert.Likewise, where someone suffers with fluctuating capacity but their evidence is important for the purposes of safeguarding, I would expect reference being made to mental health teams, not just the GP. All partners need to understand this and advise that they cannot give specialist advice. For example I would expect that primary care would clarify what they are being asked and why and signpost to other professionals who may be able to support.  |
| 14. | There were a number of agencies with intelligence about the organisation but there was a failure to pull this information together in a timely fashion which meant that there was one clear view of the likelihood of successfully recovering the situation.  |
|  | This relates to finding 9. It is clear that everyone I have spoken to had concerns about Lake and Orchard; however, these do not seem to have come together in a timely manner to enable earlier intervention. What I cannot tell is whether this was a cultural issue from those involved, by that I mean one of two things (or a combination of both):-* Were the volume of low level concerns such that complacency sets in. If you hear often enough that something which is just okay is okay does that change the barometer of what good looks like. Were the standards set high enough in the first place or were issues at Lake and Orchard described as 'oh that's just how it is at Lake and Orchard'
* Did the number of agencies involved cause an issue around understanding the true feelings of the agencies. For example, if the Local Authority were involved and had concerns, was there a view that they were waiting for health to also say they had concerns to validate what they were saying and health were waiting to be advised by the Local Authority that there were significant concerns at Lake and Orchard before being brave enough to speak out about the concerns.

It is significant that it appears only when individuals, who have not previously had contact with Lake and Orchard, become involved does the severity of the poor care result in action.  |
| 15. | The multi agency working at the end of July and into early August to close the home and safely move all residents was exemplary and ought to be celebrated as outstanding practice. |
|  | Once it became clear just how difficult things were at Lake and Orchard, the daily meetings involving all partners and the way in which all agencies came together to move those individuals that needed to be moved was exemplary practice.  |
|  | The commitment from all those staff to get those individuals to safety cannot be questioned and even where earlier opportunities were missed, the way they conducted themselves between 20 July 2020 and 20 August 2020 should be celebrated and the learning used as a mechanism to embed this good practice. |
|  | **Recommendations** |
| **1.** | **Actions from safeguarding meetings and collective care meetings must have a target date against them.** |
| **2.** | **An update to the 2018 safeguarding policy by way of standard operating procedure on how an investigation will be managed should be considered.** |
| **3.** | **The Safeguarding Adults Board should consider some guidance on a collective risk appetite statement or tolerance that helps an objective assessment of risk in safeguarding investigations.** |
| **4.** | **The agencies should agree a rating system to understand what 'good' looks like objectively. This will allow for collective care and other processes to all be aiming for the same goal with a clear way of assessing success.**  |
| **5.** | **Likewise, CQC action plans provided by Providers ought to be shared with collective care to ensure that only one action plan is required for the provider.**  |
| **6.** | **Those involved in safeguarding should receive some dedicated training in relation to leading an investigation, assessing and weighing evidence and reaching an evidence based conclusion.** |
| **7.** | **Advice and guidance should be considered to ensure that the correct 'expert' is utilised in a safeguarding investigation to ensure appropriate outcomes and evidence. This applies equally to CQC in ensuring the right expert is with them for the purposes of the investigation.**  |
| **8.** | **Training should be provided on the impact of a vulnerable individual lacking capacity during the course of a safeguarding investigation and how they can be supported to be involved in the process.** |
| **9.** | **A period of peer review and multi-agency review should be considered for safeguarding investigations before they are signed off.** |
| **10.** | **Clear evidence based risk assessments should be undertaken on both providers and individual safeguarding incidents.** |
| **11.** | **Where there are improvements made in a service which has previously been a cause for concern, Regulators and partners should not be too quick to downgrade the assessed risk level without evidence of sustained improvement.** |
| **12.** | **Organisational context needs to be considered when assessing the safety of services delivered from providers.** |
| **13.** | **Safeguarding leads in all organisations should be provided with clear guidance on escalation thresholds. This would support safeguarding leads to understand when risk is heightened that they will be supported by senior managers in the investigations and risky providers. This guidance should be aligned between local authorities and CCGs/Health to ensure that there is consistency across partners.**  |
| **14.** | **Multi agency training and documentation should be developed to raise awareness to visiting professionals on reporting what is seen when they visit providers.**  |
| **15.** | **Primary Care need to be more proactive in their role in safeguarding. If they are asked to consider signing a death certificate they should consider whether there are contextual issues within the home which would require further exploration before offering a medical cause of death and they should consider how they ensure they are safeguarding their patients when not seeing them face to face. Primary Care should also be empowered to signpost to the correct expert to comment on matters when requested as part of safeguarding.** |
| **16.** | **Primary Care should review, with the CCG, the contracting arrangements for the clinical lead and MDT for care homes. Virtual appointments should be done using video wherever possible and there should be a low threshold for visiting the home concerned. On the odd occasion (where for example a GP is isolating) where it is not possible for primary care to visit the home then contact should be made with other professionals visiting to gather intelligence through those mechanisms (for example the QIT visiting a home, DNs, CCG nursing team; a conversation between the GP to check what information is needed and a virtual round being undertaken then would be a reasonable halfway house).**  |
| **17.** | **Arrangements for closing a home should be formalised between health and social care with clear command structures and escalation processes. Including CQC role and involvement. This includes support to staff as the impact on them was significant in the closure of Lake and Orchard; the collaboration between the CCG nursing team and the Local Authority Social workers in supporting residents and an understanding of who is making decisions where there is a disagreement (for example between the Local Authority and CQC about the quality and safety of the residents in a home)** |
| **18.** | **The collective care process should be reviewed to consider whether the information from these meetings would support inspection formulation for the CQC and to ensure that there is a framework within which the Chair of collective care meetings can work to objectively assess risk.**  |
| **19.** | **The NHS and the Local Authority should undertake a review of the way therapies are delivered within the care sector. There did appear to be some confusion and lack of availability over who ought to be delivering different therapies which allows for vulnerable individuals to slip through the cracks.** |