The Regulation and Quality Improvement Authority

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Independent Review of the Actions Taken in Relation to Concerns Raised about the Care Delivered at Cherry Tree House, Carrickfergus

July 2014

Assurance, Challenge and Improvement in Health and Social Care

www.rqia.org.uk

The Regulation and Quality Improvement Authority

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

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

Foreword

14 April 2014

Dear Minister

We have pleasure in submitting the report of the Independent Review of the Actions taken in relation to concerns raised about the care delivered at Cherry Tree House between 1 January 2005 and 31 March 2013.

We appreciated especially the co-operation and goodwill of relatives of residents from Cherry Tree House and others, including whistleblowers, and those representing whistleblowers. We know that reliving their experiences was difficult for many of them, however their contribution was vital to assist us in undertaking our task.

We wish to express our sincere thanks to all those who contributed to the process of collating and sharing information with us. Staff from the DHSSPS, RQIA and the HSC Trusts were most helpful throughout the process.

Finally we would wish to pay tribute to the RQIA team who supported us through the review. Patricia Corrigan assisted as the Project Administrator and for her contribution we are very grateful. We especially wish to place on record the support and assistance of Angela Belshaw, the Project Manager. Angela's experience, knowledge, courtesy and integrity was fundamental to the completion of our work.

We trust that this review, and especially the recommendations, will assist the service in reviewing the processes required to deliver high quality and safe care within the Nursing and Residential care home sector.

Peter Gibson

Eleanor Hayes

Elsbeth Rea

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1.0 Background to the Review

On 9 September 2013, the Chief Medical Officer, Department of Health Social Services and Public Safety (DHSSPS) wrote to the Chief Executive Officer, Regulation and Quality Improvement Authority (RQIA) commissioning an independent review of the actions taken in relation to concerns raised about the care delivered at Cherry Tree House Private Nursing and Residential Home in Carrickfergus. (Appendix 1)

In commissioning this review the Chief Medical Officer stated in his letter:

"Concerns in respect of Cherry Tree House have arisen since 2005 from whistle-blowing allegations by staff to external parties, complaints raised by families and concerns raised by the NHSCT[1]. In addition, RQIA has taken regulatory enforcement action following inspections of the facility. Although investigations have been conducted, it is not clear, at this stage, whether all concerns / allegations were investigated - this is because there was a wide range of organisations / individuals and data sources involved."

In addition, he stated, "given the long history of allegations the Department's aim is to seek external assurance that all appropriate actions have been taken, as past action or inaction can have consequences for the future; to this end the collation and evaluation by RQIA of all identifiable, relevant information from the range of sources held within Trusts, DHSSPS, RQIA and involved organisations will be important".

The DHSSPS agreed that in undertaking the review, and in drafting of the Review Report, the review team would work within the RQIA governance framework, paying particular reference to issues relating to information governance, client confidentiality, and data protection.

The review covers the period from 1 January 2005 to 31 March 2013.

[1] NHSCT Northern Health and Social Care Trust

1.1 Terms of Reference of the Review

The original terms of reference for the review were:

1. To collate and deliver a chronology of the evidence, allegations and / or disclosures (both anonymous and attributable) made to external parties relating to the care at Cherry Tree House, including concerns:

- Raised by families
- Raised by former and existing staff members, or
- Brought to the attention of relevant bodies including, DHSSPS, Health and Social Care Board, Health and Social Care Trusts, PSNI and RQIA

2. To prepare a chronology of all the actions taken by relevant organisations in response to this evidence, allegations or disclosures to share information, investigate allegations and take forward the requirements and/or recommendations of any subsequent reports or regulatory activity.

3. To identify if there were any gaps or deficiencies in respect of the actions taken in response to the evidence, allegations or disclosures by any of the bodies, and make recommendations to address issues identified from this analysis including those around working together.

4. To identify any learning from the actions taken, and make recommendations to take this forward.

In January 2014, the Minister of Health, Social Services and Public Safety extended the terms of reference to include:

5. To engage with families and others who had reported concerns regarding the care and treatment of residents in Cherry Tree House during the timeframe covered by this review.

1.2 Methodology

The review team requested access to all documents from January 2005 to end of March 2013 relating to Cherry Tree House from the following organisations:

- Department of Health and Social Services and Public Safety (DHSSPS)
- Health and Social Care Board (HSCB)
- Regulation and Quality Improvement Authority (RQIA)
- All Health and Social Care Trusts (HSC)

Each organisation provided information in respect of complaints, allegations or concerns which were brought to their attention by families, residents and Cherry Tree House staff, including whistleblowers. Organisations were asked to provide documentary evidence of investigations and actions taken in relation to those complaints, allegations or concerns. In addition the Regulation and Quality Improvement Authority provided all inspection reports covering the review period.

Evidence was received from the Northern Health and Social Care Trust (NHSCT), the Belfast Health and Social Care Trust (BHSCT), DHSSPS and RQIA.

This data was then collated into three interrelated chronologies;

- Chronology of Complaints and Untoward Incidents
- Chronology of Whistleblowing events
- Chronology of RQIA Inspections

The review team requested clarification from the DHSSPS in respect of governance and quality monitoring arrangements within Health and Social Care (HSC).

Further to the extension of the review team's remit, a public notice was placed in newspapers on 18 February 2014. The notice invited those families and others who had expressed concerns to a public body or statutory authority relating to the care and treatment of residents at Cherry Tree House Private Nursing and Residential Home in Carrickfergus between January 2005 and March 2013, to contact the review team.

The review team met with family members and staff, including whistleblowers, who had contacted them.

The review team consulted with Assistant Chief Inspector, Care and Social Services Inspectorate Wales (CSSIW) to discuss best practice in Wales in respect of the regulation of nursing and residential homes.

This report is based on the evidence submitted by the above organisations and meetings with families and others.

1.3 Membership of the Review Team

The independent review team members appointed in October 2013 to undertake this work were:

Mr Peter Gibson	Former Deputy Director of Social Services, Eastern Health and Social Services Board
Mrs Eleanor Hayes	Independent Health Care Consultant Former Director of Nursing, Belfast City Hospital Trust
Mrs Elsbeth Rea	Independent Social Work Consultant

The independent review team was supported by RQIA staff:

Mrs Angela Belshaw	Project Manager
Ms Patricia Corrigan	Project Administrator

1.4 Organisations responsible for ensuring the quality of care in Nursing and Residential Homes

Responsibility for ensuring the quality of care falls to providers, commissioners and regulators of care.

1.4.1 Providers

The responsible person / registered provider of the nursing or residential care home has prime responsibility for ensuring that good quality care is provided. Registered providers must comply with statutory regulations and are expected to comply with the minimum standards for care.

1.4.2 Commissioning and Contracting

The Health and Social Care Board (HSC) is responsible for commissioning health and social care services, including places in nursing and residential homes. The HSC Board has contracts with Trusts who in turn contract with a range of independent providers to meet the assessed needs of individuals within Trust areas.

Trusts have a duty to ensure that providers are adhering to the terms of the contract and have a responsibility to review the care provided to individuals for whom the trust is paying all, or part, of the cost of care.

All five Trusts cooperate in ensuring that there is a common Northern Ireland-wide (“regional”) contract between Trusts and providers of residential and nursing homes.

1.4.3 Regulation

The Regulation and Quality Improvement Authority is responsible for the regulation (which includes registration and inspection) of Nursing and Residential Homes and inspects against:

- The Nursing Homes Regulations (Northern Ireland) 2005
- Residential Care Homes Regulations (Northern Ireland) 2005
- The DHSSPS Nursing Homes Minimum Standards (January 2008)
- The DHSSPS Residential Care Homes Minimum Standards (2008 updated August 2011)

1.4.4 Cherry Tree House Nursing and Residential Home

Cherry Tree House Private Nursing and Residential Home was opened on 1 June 1989. The owner of the establishment is registered with RQIA as the responsible person / registered provider and has overall responsibility for the care provided in the home.

The home is situated on the North Road in Carrickfergus and is a two storey building providing services and facilities for 56 patients / residents. The Home comprises of two units caring for Nursing and Residential residents.

Accommodation comprises lounges, dining rooms, bedrooms and a range of bathroom, shower and toilet facilities. Bedrooms are located on both ground and first floor and are either single (with or without en-suite facilities) or double rooms. The first floor is accessed by stairs and a passenger lift.

The Home is staffed by qualified nurses who work alongside care assistants to provide care 24 hours a day, seven days a week. Staff work on a full time, part time or bank capacity. In addition, there are kitchen, laundry and housekeeping staff.

The Home Manager (a registered nurse) is registered with RQIA as manager and has overall responsibility for the day to day management of Home.

Cherry Tree House is currently registered to provide care for persons under the following categories of care: Learning Disability, Mental Health Condition, Old Age and Physical Disability.

1.5 Report

The findings of this review in respect of Complaints and Untoward Incidents, Whistleblowing and RQIA Inspections of Cherry Tree House, are presented respectively in sections 3, 4 and 5 of this report. Each of these sections delivers a chronology of events; the review team's analysis and discussion of the evidence provided, and recommendations in respect of addressing issues arising from identified gaps or deficiencies. In these chronologies, we refer to Cherry Tree House as CTH.

Appendix 3 is a graphical and summary representation of the 3 chronologies over each year of the review period.

The report concludes in section 6 with a collation of the review team's recommendations. These have been designed to help organisations take forward the issues that have led to this review.

2.0 EXECUTIVE SUMMARY

This section summarises the main findings of the review team following its analysis of the chronologies and meetings with families and others in respect of Complaints and Untoward Incidents, Whistleblowing and RQIA Inspection of Cherry Tree House.

Complaints and Untoward Incidents

The review team acknowledge that the legislative basis and organisational procedures for handling complaints and untoward incidents changed during the time period of the review and that there were two relevant complaints procedures. They also note that Trusts and RQIA have differing but complementary roles in monitoring the care provided in a home.
The review team examined records of 65 complaints and untoward incidents which had been made between 26 January 2005 and 17 January 2013. These included those complaints received by Cherry Tree House and reported by the home to the appropriate authorities; those complaints received directly by these authorities; and untoward incidents which had been reported to the authorities.

These events identified issues within four areas of concern which are set out below, together with their incidence.

(a) Allegations of abuse (19), including 12 allegations of abuse by staff;

(b) Personal care in respect of individual residents (27), including complaints about poor care standards, poor nutrition, dehydration and continence care;

(c) Other care issues (40), including residents falling, poor levels of hygiene, loss of residents' property and the management of medicines; and

(d) Staffing (13), including poor staff attitudes and inadequate staffing levels.

The review team's findings, based on the written evidence of these 65 complaints and untoward incidents, indicate that, with some exceptions, procedures were followed by the Trusts, RQIA and the PSNI. There was also evidence of good inter-agency cooperation. However, the minutes of some vulnerable adult strategy meetings did not identify those to be interviewed during the investigation and, in some instances, RQIA did not follow up on the issues raised in complaints during the next inspection of the home.

Those who had made complaints and who met with the review team expressed concerns regarding how their complaints were handled and provided the review team with a very different perspective. While organisations may have perceived that they handled complaints appropriately, families and others whom we met expressed dissatisfaction with actions taken. They were also particularly critical of Cherry Tree House's management of their complaints.

Whistleblowing

The review team considered 55 whistleblowing issues or events which had been recorded from 2 March 2006 to 1 March 2013 and had been drawn to the attention of:

- Cherry Tree House;
- RQIA;
- NHSCT;
- DHSSPS;
- Northern Ireland Human Rights Commission; and
- Northern Ireland Ombudsman for Complaints.

A significant number of these events related to the actions of one whistleblower referred throughout as "WB" in this report. The chronology also reflects WB's journey as she raised her concerns and allegations with public bodies throughout the period reviewed. These communications and meetings resulted in her disclosures being shared with other agencies for investigation. This documentation was provided to the review team. The review team is of the opinion that WB both consistently and persistently pursued her issues of concern, but appears to have been frustrated in her attempts to resolve these locally and escalated them to other agencies. Without compromising the protection of data and respect of confidentiality, reassurance that her disclosures were being heard may have alleviated WB's concerns to some extent.

The review team also examined documents provided by a range of sources including RQIA, Trusts and DHSSPS. In addition, families and others gave us evidence at meetings. Some of these concerned issues which WB raised with Cherry Tree House management. As these were not raised with outside organisations when they occurred, they were outside the remit of the review.

Other whistleblowers who expressed concerns about care at Cherry Tree House included an agency Care Assistant; 3 Care Assistants on night duty (including WB); 3 members of Cherry Tree House staff; "An Observer, Carrickfergus"; and 2 other members of Cherry Tree House staff each of whom made separate allegations.

The review team's analysis of the whistleblowing events identified issues within 4 main areas of concern which are set out below.

(a) Allegations of the abuse of residents were mentioned at least 16 times.

(b) Standards of care delivered to residents were mentioned at least 25 times. The issues included the management of continence; abuse of residents by staff and by other residents; and the moving and handling of dependent residents.

(c) Other care issues were mentioned at least 15 times. These included the poor level of hygiene in the home, record keeping issues and the failure to implement procedures for the protection of vulnerable adults.

(b) Staffing was mentioned at least 16 times and included issues relating to shortages of staff; the lack of training for staff; poor communication between management and staff; and the lack of support for whistleblowers.

Other concerns (which were mentioned at least 15 times) included the poor level of hygiene in Cherry Tree House; the standard of record keeping and removal of records; and failure to implement procedures for the protection of vulnerable adults.

In addition to meeting with WB, the review team met with representatives from Patients First (an organisation which represents whistleblowers in the HSC) who acted as a conduit for those former members of staff of Cherry Tree House who had previously raised concerns and subsequently submitted their views to the review team. It was their view that, despite the Minister's letter of 22 March 2012, there is often little internal or external support for whistleblowers who wish to raise concerns regarding patient care. They expressed concern at the DHSSPS's level of commitment to implement a robust policy in relation to protection for whistleblowers. We understand that this group has identified a number of ways to enhance the current whistleblowing strategy and is willing to collaborate with the HSC to achieve this. The review team acknowledge the potential for whistleblowers to become isolated within the workplace and has noted WB's feelings of being bullied.

The review team note that a number of whistleblowing initiatives are being developed throughout the U.K, such as NHS Scotland's confidential telephone line which has been in place since April 2013 for staff who want to raise concerns.

From the evidence available to the review team it is clear that significant time and resources were spent trying to investigate allegations made by WB. We recognise that statutory organisations have difficulties in investigating allegations of historical abuse and poor care practice because residents may have died or staff moved on. However, the review team believe that if, after being investigated, complaints had been followed through, and if contemporaneous records in Cherry Tree House had been inspected, some of these matters could have been addressed at the time they occurred. The management of continence was a recurring issue raised by WB over many years and the review team note that, on 1 March 2013, a new whistleblower made allegations about issues, including continence management, general standards of care and inadequate staffing levels. The review team note that these had been matters of concern for WB and others over the period of the review.

Inspections

There were 43 inspections undertaken by RQIA during the period of the review beginning with an unannounced inspection on 7 February 2005 and ending with an unannounced medicines management inspection on 14th March 2013. In reporting on these, the review team appreciate that some of its findings apply to historical aspects of the inspection process which are not

current practice. It is intended that our comments will assist RQIA in any future consideration of its inspection process.

The review team considered the following elements of the inspection process:

- RQIA's programme of investigating a number of standards and "themes" each year;
- Pre-inspection planning including the collection and use of pre-inspection intelligence;
- Evidence recorded in inspection reports in respect of compliance with:
  - standards being inspected
  - requirements and recommendations from previous inspections;
- Inspection report templates;
- Quality Improvement Plans; and
- Enforcement action by RQIA.

In addition to the above, findings in respect of Pharmacy/ Medicines Management inspections and Estates inspections are also reported.

During the period under review, the review team found that there was evidence that the RQIA took enforcement action in respect of Cherry Tree House on 3 occasions. The review team noted that there was evidence that, while RQIA considered taking enforcement action on 2 occasions, this was not followed through.

The review team has been critical of some aspects of RQIA's inspection methodology and practices and including RQIA's limited use of enforcement powers. However over this period of 8 years, the reports of inspections clearly demonstrated that Cherry Tree House was consistently failing to comply with Regulations and meet minimum standards of care.

Families reported that, while they were aware of when announced inspections were to take place in Cherry Tree House, some suggested that they were unaware that they could speak to inspectors and would have liked the opportunity to do so. Many families were not aware that unannounced inspections also took place. Others reported that staff were discouraged to report concerns to inspectors and were also reluctant to raise concerns because they knew that inspectors were obliged to report their comments back to management.

Families and others interviewed by the review team raised concerns about the effectiveness of the RQIA inspection process to detect and address shortcomings in the care provided. They observed a "flurry of activity", such as to clean and tidy the home prior to announced inspections, which they felt gave a false picture about what normally would happen on a daily basis in Cherry Tree House. Some relatives and others reported concerns about how thoroughly inspectors checked for evidence during their visits. For example some relatives reported that there were frequent shortages of bed linen and continence products. However others advised the review team that these storage cupboards were locked while RQIA inspectors were on the premises.

One relative (who had examined the inspection reports during the period that her relative was in the home) commented that “inspections resulted in the same requirements and recommendations made to Cherry Tree House year after year”. This relative further observed that, because issues, including complaints management, were “mentioned in one report and not checked on the next inspection, meant that issues were allowed to continue over a long period of time”. There was a belief that inspections did not lead to any improvements in the home. The following comment of one family member was representative of the views of others the review team met - “Why were problems not dealt with and why was Cherry Tree House not closed?”

In addition, some of those who met the review team expressed concern that Cherry Tree House had employed, in senior management roles, staff who had left previous employment following their practice being called into question. They commented that it was too easy for staff who had been dismissed in one home to move to another and felt that there are inadequate controls in place to prevent this happening.

Conclusion

The provision of good quality care for older people in nursing and residential homes is a major challenge for modern society. Elements to ensure such care include:

- Nursing and residential homes which are focused on delivering the fundamental aspects of care through appropriately trained staff;
- Local commissioning of high quality services through person centred care planning;
- Robust and responsive regulation to ensure the minimum care standards are maintained; and
- Family members and others, including staff, who are empowered to act as advocates for those older people who are unable to speak for themselves.

The review team found evidence of good practice by those responsible for monitoring the care provided by Cherry Tree House and also evidence of families and staff raising concerns about that care. However we found that aspects of each of the four elements, above, failed at times during the period reviewed.

As a result of reviewing in detail the complaints, untoward incidents, whistleblowing and inspection reports, the review team conclude that Cherry Tree House was failing to comply consistently with the minimum care standards. There was evidence that the same issues of concern about care at Cherry Tree House were highlighted on a regular basis and where improvements were made they were often not sustained.

In line with current policy, in respect of complaints regarding elderly residents, the Northern Trust relied on Cherry Tree House management to provide the assurance regarding the quality of care. Trusts should review their monitoring

and assurance processes to ensure that complaints about their residents are appropriately managed and resolved.

While RQIA's inspection reports highlighted shortcomings in the care provided at Cherry Tree House, the review team conclude that there were opportunities for RQIA to take a more rigorous approach to the enforcement of Regulations and Minimum Care Standards. In addition the failure to consistently use the "intelligence" available about Cherry Tree House, led to fundamental aspects of care not being reported on in the inspection reports.

Families and others communicated their lack of understanding in escalating complaints about the care in Cherry Tree House to external bodies. They did not understand the roles and responsibilities of health and social care organisations in respect of handling complaints. They had limited knowledge of support available to complainants.

The review team found that staff who raised concerns felt they received little support from Cherry Tree House and the external bodies they contacted. The main whistleblower, frustrated by the apparent lack of response to her concerns, felt obliged to raise these issues with the Minister.

The review team hopes that this report and recommendations will lead to improved nursing and residential home care for older people in Northern Ireland.

3.0 Complaints and Untoward Incidents

This section outlines the legislative basis and organisational procedures for handling complaints and untoward incidents before delivering a chronology of 65 such events recorded by the review team between 26 January 2005 and 17 January 2013. The section then discusses the responses of the relevant external organisations to these. It summarises the views of families and other who met with the review team before concluding with a range of recommendations.

3.1 Legislation and Policy

Regulation 30 "Notification of deaths, illness and other events" of the Nursing Home Regulations (Northern Ireland) 2005 requires registered establishments to inform RQIA of untoward incidents / notifiable events which occur in the home. Registered providers are expected to notify RQIA in accordance with the statutory regulations governing the service. RQIA proformas are available from the RQIA website.[2]
NB Throughout this report, notifiable events are referred to as untoward incidents.

During the period of this review - 2005 to 2013 - there were two relevant complaints procedures:

1. The Health and Personal Social Services (HPSS) Complaints Procedure 1996

2. Complaints in Health and Social Care (HSC) April 2009

In the context of the 1996 procedure, DHSSPS issued Circular HSC (SQSD) 31/2007 "Guidance on complaints in residential and nursing homes". This stated that, while complainants were to be encouraged to raise their concerns with the residential or nursing home, they could raise the matter with the Trust that had commissioned the care for the individual. If a complainant was not satisfied with the response at "local level" (i.e. the home or the Trust) the complaint could be raised with RQIA. If the complainant remained dissatisfied, they could refer their complaint to the Ombudsman. In addition RQIA had a duty to investigate any complaint about a failure to comply with Regulations.

From September 2006, complaints relating to the possible abuse of vulnerable adults were investigated in line with the Regional Adult Protection Policy issued by the DHSSPS.

In the context of the 2009 procedure, the DHSSPS issued Circular HSC (SQSD) 23/2009 "Guidance on complaints handling in regulated

2 http://www.rqia.org.uk/what_we_do/registration__inspection_and_reviews/notifiable_events.cfm

establishments and agencies". As with the previous arrangements, individuals were able to raise their concerns either with the provider or the Trusts. From April 2009, RQIA was no longer responsible for investigating complaints that had not been resolved at a local level (i.e. by Cherry Tree House or the Trust). However, if a complainant was not satisfied with the response at the local level, they could now refer their complaint directly to the Ombudsman, rather than to RQIA. RQIA's responsibilities included the oversight of how Trusts and regulated establishments were implementing the complaints procedure.

Regulation 24(8) of the 2005 Regulations states that; 'The registered person shall supply to the Regulation and Improvement Authority at its request a statement containing a summary of the complaints made during the preceding twelve months and the action that was taken in response.'

The Regional Contract and Service Specifications also require homes to report any serious adverse incident to the relevant Trust.

The review team believes that there is a deficiency in the provisions for the handling of complaints in Nursing and Residential Homes in the Regulations and the DHSSPS policy of 2009. Neither the Regulations, nor the DHSSPS policy, place an obligation on homes to inform the HSC Trust that a complaint has been made in respect of a resident for whom the Trust has responsibility, how the complaint was investigated and the outcome of the investigation. We believe that homes should be required to report to the relevant trust any complaint that has been made by a resident, family or whistleblower.

3.2 Roles and Responsibilities

Trusts and RQIA have differing but complementary roles in monitoring care provided in a registered home.

- Trusts have a responsibility to ensure that homes have in place appropriate care plans for residents from their area.
- RQIA has a statutory responsibility for ensuring that quality of care is in line with regulation and standards. RQIA registers and inspects a wide range of services delivered by HSC bodies and by the independent sector. The regulation of services is based on new minimum care standards to ensure that service users know what quality of services they can expect to receive, and service providers have a benchmark against which to measure their quality

However, the prime responsibility for delivering good quality care to individual residents lies with the home's registered provider and registered manager.

3.3 Complaints and Untoward Incidents Chronology

The review team examined the records of 65 complaints and untoward incidents / notifiable events

These included:

- Complaints received by Cherry Tree House about which the home informed the NHSSB Registration and Inspection Unit (R&I unit), RQIA or the relevant Health and Social Care trust / legacy trust.
- Complaints made directly to the NHSSB Registration and Inspection Unit, RQIA, NHSCT, BHSCT or legacy trust.
- Untoward incidents reported to NHSSB Registration and Inspection Unit, and RQIA by Cherry Tree House, some of which were also raised as complaints.

These events are recorded in the chronology below.

The review team only had access to complaints made to Cherry Tree House which were then forwarded to statutory agencies.

3.3 Complaints and Untoward Incidents Chronology (referred to in cross references as (Complaint Chronology).

C =complaint **UI**=untoward incident

	Complaint/ Untoward Incident	Organisations involved	Outcome	Review Team's Findings/Gaps
1 UI	26 January 05 Investigation into missing drugs in CTH.	NHSSB R & I Unit	Investigation by CTH.	No evidence found in report of inspection 7/02/2005 (No1) that this incident was reviewed.
2 UI	31 January 05 Assault by one resident on another.	NHSSB R & I Unit	Investigation by CTH and resident asked to leave home.	
3 UI	21 March 05 Allegation of an incident of physical abuse by staff member on resident.	NHSSB R & I Unit	Investigation by CTH who concluded that the allegation was not substantiated.	
4 C	25 April 05 Complaint received by CTH from family member re care issues: lack of bed rails.	RQIA	CTH gave family notice for resident to be moved to another home.	
5 C	3 May 05 Complaint to RQIA by community nurse re staff attitude in respect of a resident's care.ie staff attitude, staff shortages.	RQIA NHSCT	Investigation by CTH who found that allegation was not substantiated.	Policies and Procedures followed.
6 C	23 May 05 Complaint to RQIA from a family member re loss of jewellery	RQIA PSNI	RQIA advised complainant to seek compensation from CTH.	Review team did not see evidence of compensation being requested or paid.
7 UI	14 July 05 Allegation of two residents fighting.	RQIA NHSCT.	Arrangements made for one resident to be moved to specialist EMI home.	

	Complaint/ Untoward Incident	Organisations involved	Outcome	Review Team's Findings/Gaps
8 UI	17 August 05 Allegation of theft of money from a resident.	RQIA PSNI Homefirst Trust	Allegation was not proven.	Policies and Procedures followed.
9 C	17 November 05 Complaint from family member re allegation of sexual assault / male resident to female resident.	RQIA Homefirst Trust	CTH and Trust found that allegation was not proven.	Policies and Procedures followed by Trust and RQIA.
10 UI	28 November 05 Allegation of physical abuse to residents by 2 staff members.	Homefirst Trust RQIA	Investigation by CHT. One staff member resigned. Other member of staff dismissed.	Policies and Procedures followed. The review team notes this was prior to registration of care workers by NISCC.
11 C	4 January 06 Family member contacted RQIA re care concerning mother i.e. communication, neglect.	RQIA	Unannounced Complaints inspection was conducted by RQIA on 4/01/06 and complaints substantiated.	Prompt action by RQIA. The review team noted that subsequent care inspection reports did not refer to this complaint inspection. .
12 C	5 January 06 Family member raised complaint to CTH re staff attitudes. Allegations by resident of physical abuse.	RQIA Homefirst Trust PSNI	CTH investigation findings were accepted by other organisations. Allegations not substantiated.	Review team did not see evidence of investigation.
13 UI	13 February 06 CTH informed RQIA of an allegation of physical abuse by a member of staff.	RQIA Homefirst Trust PSNI	CTH investigation findings were accepted by other organisations. Allegation not substantiated.	

	Complaint/ Untoward Incident	Organisations involved	Outcome	Review Team's Findings/Gaps
14 C	13 February 06 Family member allegation of neglect to mother in respect of medical attention, weight loss. CTH informed RQIA.	RQIA Homefirst Trust	Unannounced complaints inspection on 15/02/06 which identified inconsistencies with care provided and learning opportunities**.** Resident was transferred to another home following discharge from hospital as CTH refused readmission.	Prompt action by RQIA. The review team noted that subsequent care inspection reports did not refer to this complaint inspection.
15 C	27 February 06 Family member complaint to RQIA re receiving anonymous telephone calls from staff re care issues. Falsifying of care records and concern re mother's fracture sustained in October 2005.	RQIA	RQIA advised complainant to refer complaint to CTH.	The review team met with the complainant in respect of these complaints. (No 11, 12, 14 and 15) The family remain dissatisfied with the quality of investigations and the authorities' acceptance of internal investigations by CTH. The family believe that they were considered a "problem family" by CTH management.
16 UI	2 March 06 Anonymous call from an agency Care Assistant to RQIA re staffing levels and incident re a resident's fall and that Matron had refused to come into the home.	RQIA	RQIA requested report from CTH. Report submitted to RQIA and it was acknowledged that CTH was short staffed that pm. The manager advised	See Whistleblowing chronology (No1). The review team note RQIA's acceptance of CTH's manager investigating a complaint about herself.

	Complaint/ Untoward Incident	Organisations involved	Outcome	Review Team's Findings/Gaps
			RQIA that she was contacted that evening and gave appropriate advice and support to staff. RQIA accepted findings.	
17 C	22 March 06 Anonymous caller to RQIA alleging physical abuse of resident.	RQIA	Investigated by CTH manager. Allegation not substantiated.	
18 C	16 May 06 Complaint to RQIA by family member re care in CTH e.g. lack of laundry, poor moving and handling practice, nutrition, physical abuse by another resident.	RQIA Homefirst Trust	RQIA advised complainant to raise concerns at forthcoming review meeting.	Good interagency working to produce a satisfactory outcome for the complainant.
****Change of responsibility for investigation of complaints under Regional Vulnerable Adults Procedures 2006****				
19 C	18 September 06 Complaint made to Trust re care of resident's nutritional needs. Trust informed RQIA.	Homefirst Trust RQIA	RQIA file note states that Trust staff member advised that "her team is not investigating complaints in Homes due to time restraints." Resident awaiting transfer to another home.	Review team note with concern the Trust's response re complaint. Same complainant as No18 above. It was reported that relative did not wish to make a formal complaint for fear of reprisals to resident.

	Complaint/ Untoward Incident	Organisations involved	Outcome	Review Team's Findings/Gaps
20 UI	27 January 07 CTH reported the theft of drugs to RQIA.	RQIA PSNI	RQIA Pharmacy investigation visit on 1/02/2007. Investigation conducted and staff member dismissed for gross misconduct and negligence.	Policies and Procedures followed.
21 UI	14 February 07 CTH reported to RQIA a fire in staff room – faulty toaster.	RQIA	Investigation by CTH.	Policies and Procedures followed. Estates inspection on 27/11/2007 Inspection Chronology (No 20) noted significant fire risks.
22 C	5 April 07 Anonymous complaint to RQIA re staffing and Health and Safety in CTH.	RQIA	1. Complaint inspection carried out on 6/04/2007. RQIA wrote to NHSCT suggesting a temporary restriction to admissions. 2. Letter sent from RQIA to CTH Proprietor re concerns regarding staffing levels.	1. Prompt action by RQIA. Inspection Chronology (No 15). 2. Review team saw no evidence of response to this letter.

	Complaint/ Untoward Incident	Organisations involved	Outcome	Review Team's Findings/Gaps
23 C	4 June 07 Family member complaint to NHSCT re allegations of poor care, issues re environmental cleanliness, lack of privacy and dignity, physical abuse and loss of property	NHSCT RQIA	Trust and CTH staff met on 7/06/2007 and on 1/08/2007. Trust kept RQIA advised on progress of this matter. Resident transferred to another home in September 2007.	Policies and Procedures followed.
24 UI	21 January 08 CTH reported to RQIA assault by one resident on another.	RQIA NHSCT	Letter to CTH from RQIA requesting follow up report to this incident.	
25 C	23 January 08 NHSCT advised RQIA re concerns about pressure sores and incomplete recording of tissue viability and nutritional risk assessments in CTH.	NHSCT RQIA	1. RQIA advised Trust to communicate concerns with CTH. 2. RQIA informed the Trust that they would follow up these issues at the next inspection. 3. RQIA requested copy of CHT letter of response to Trust and details of staff training. Training took place on 13/03/2008.	1. NHSCT staff acted appropriately. 2. No evidence that these were examined at the next inspection on 21/08/2008. Inspection Chronology (No 22). The review team note the time delay between January and August 2008.

	Complaint/ Untoward Incident	Organisations involved	Outcome	Review Team's Findings/Gaps
26 UI	22 April 08 CTH informed RQIA of resident falling and sustaining a fracture.	RQIA	RQIA request investigation report / how this resident's risks were assessed and updated. Findings were accepted by RQIA.	
27 UI	25 April 08 CTH informed RQIA that a resident had fallen and sustained a fracture.	RQIA	RQIA request investigation report/ how this resident's risks were assessed and updated. Findings were accepted by RQIA.	
28 C	16 May 08 Family member complained to BHSCT re relative's painful hip and not informed of fracture.	BHSCT RQIA	CTH informed RQIA / BHSCT that while the resident was noted to have sustained a fractured femur and dislocated hip they were not as a result of a fall. BHSCT requested an investigation. Trust not content with initial response from CTH and asked for, and received, a follow up report.	Appropriate action by BHSCT It is of note that this was the third fracture in 3 weeks reported in CTH and an inspection was not conducted until 21/08/2008. The review team saw no evidence that the 3 incidents were followed up during that inspection. Inspection Chronology (No 22).

	Complaint/ Untoward Incident	Organisations involved	Outcome	Review Team's Findings/Gaps
29 UI	3 July 08 CTH reported to RQIA an occurrence of CDifficile in a patient recently admitted from hospital.	RQIA	RQIA was advised by CTH that infection control procedures were put in place.	
30 C	18 July 08 Family member complaint to NHSCT including resident's weight loss/ lack of heat/ lack of medical attention.	NHSCT RQIA	Trust investigated and replied to complainant.	Substantive response by Trust to complainant. RQIA file note of 18/08/2008 states that the complainant's issues would be looked at during the next inspection. Inspection Chronology (No 22). The review team saw no evidence of this in the inspection report.
31 UI	26 August 08 CTH advised RQIA of theft of a necklace from a resident.	RQIA PSNI	Investigation undertaken by PSNI and necklace retrieved.	Policies and Procedures followed.
32 UI	3 September 08 CTH reported resident found fallen and bleeding from back of head.	RQIA	RQIA requested report of investigation. Report was provided.	Policies and Procedures followed.
33 UI	5 September 08 CTH reported to RQIA outbreak of Vomiting and Diarrhoea.	RQIA NHSSB Environmental Health	Public Health advice followed.	Policies and Procedures followed.

	Complaint/ Untoward Incident	Organisations involved	Outcome	Review Team's Findings/Gaps
34 UI	16 October 08 CTH reported resident had fallen out of bed. Transferred to hospital, no injuries were noted.	RQIA	RQIA requested investigation. Report was provided.	Policies and Procedures followed.
35 UI	6 December 08 CTH reported resident had fallen transferred to hospital, no injuries noted.	RQIA	RQIA requested a report. Report was provided.	Policies and Procedures followed.
36 C	13 January 09 Family member complaint to RQIA re lack of activities for residents, decline in hygiene and appearance of the environment.	RQIA	RQIA contacted CTH manager who advised that deep cleaning was taking place in the Home and there was an activities programme in place.	Review team note that at the next inspection 14/05/2009 Inspection Chronology (No 26) the main focus was on Infection Prevention and Control. This inspection identified significant issues. Requirement for Activities Therapist for residents was an on-going issue.
37 UI	22 January 09 CTH notified RQIA of medicine error when it was noted a resident had been without medication for 8 days.	RQIA	Unannounced Medicines inspection 26/01/2009 addressed this issue. RQIA requested an investigation and report into the medicines incident.	3/03/2009 RQIA requested further information. No evidence that the investigation report was ever received despite reminders from RQIA, although CTH manager stated it had been sent to RQIA.
38 C	23 April 09 WB met with Chair of Health Committee and advised her of historical abuse dating back to 2007 in CTH. In addition WB	DHSSPS RQIA NHSCT BHSCT PSNI	A letter was sent from the Chair of the Health Committee to the Minister requesting that the allegations should be	Refer Whistle Blowing Chronology (No 20). Good interagency working noted.

	Complaint/ Untoward Incident	Organisations involved	Outcome	Review Team's Findings/Gaps
	provided evidence of poor quality of care and communication issues.		investigated. 1. DHSSPS contacted the NHSCT and RQIA re this letter and requested that all relevant safeguarding protocols to be initiated. Supporting documentation was given to RQIA at the same time. 2. DHSSPS sought assurance from the NHSCT and BHSCT that residents would be reviewed in light of these allegations. Assurance was subsequently given in letters to the DHSSPS. 3. Safeguarding Strategy Meeting with PSNI and Trust staff was held on 1/05/2009 to discuss how to proceed with the investigation. 4. Safeguarding Review Meeting on 3/07/2009 noted that the allegations of abuse could not be substantiated. 5. RQIA advised DHSSPS on 6/05/2009	This inspection report Inspection Chronology (No 26) makes no

	Complaint/ Untoward Incident	Organisations involved	Outcome	Review Team's Findings/Gaps
			that "the inspector would ensure that the care issues as identified in the correspondence would be examined during the inspection planned for May 2009."	reference to the issues raised by WB. WB advised the review team that she did not receive any feedback in relation to the concerns raised.
39 C	15 June 09 Anonymous complaint to RQIA re cleanliness of CTH.	RQIA	RQIA requested report from CTH Investigation and disciplinary action taken by CTH manager.	
40 C	16 June 09 Family member complaint to a nursing agency regarding the behaviour of a staff member to her relative.	Nursing Agency NHSCT	Formal disciplinary action taken against staff member by agency.	Policies and Procedures followed.
41 C	24 June 09 WB reported to RQIA (1/07/2009) incident of verbal abuse by staff member to resident.	RQIA NHSCT Nursing Agency	CTH conducted investigation and suspended care worker. Safeguarding Strategy meeting was convened by NHSCT on 5/11/2009 Care Assistant was suspended and finally dismissed on 10/11/2009.	Policies and Procedures followed. Whistleblowing Chronology (No 24).

	Complaint/ Untoward Incident	Organisations involved	Outcome	Review Team's Findings/Gaps
42 C	28 September 09 Family member raised complaint with CTH Proprietor and RQIA re care in CTH. e.g. mobility, verbal abuse, dehydration, environmental cleanliness, personal hygiene, loss of property, sacral sore.	RQIA	Investigated by Proprietor and responded to complainant on 19/11/2009. RQIA felt there were shortcomings in the response and requested further information 4/02/2010 and further clarification on15/03/2010 which was subsequently provided on 24/03/2010.	Appropriate challenge by RQIA, although time delays are concerning to the review team. At the next Inspection on 11/05/2010 Inspection Chronology (No 30) there was no evidence that the issues raised in this complaint were examined.
43 C	11 November 09 Letter of complaint sent to RQIA from 3 CTH staff members re two residents receiving preferential treatment.	RQIA	Investigated by CTH manager. RQIA raised concern that the manager investigated a complaint in which she was implicated. Registered provider was requested to provide assurance of satisfaction with the rigour of the investigation.	RQIA pursued this issue until it was satisfied that the matter had been investigated appropriately. Whistleblowing Chronology (No 27).
44 C	8 January 10 Letter of complaint from family member to RQIA re neglect of resident in CTH e.g. pressure sore, dehydration, catheter care, poor nutritional care, staff	RQIA NHSCT	RQIA requested registered provider to investigate allegations. Safeguarding case conference took place 23/02/2010. Action	

	Complaint/ Untoward Incident	Organisations involved	Outcome	Review Team's Findings/Gaps
	shortage, medicines not administered correctly. Environmental cleanliness. Lack of investigation of issues.		included - recording of food and fluids to be recorded accurately in the home. Safeguarding case conference 10/03/2010 Action plan included: • Personal hygiene and care of incontinent residents to be monitored • Recording of food and fluid intake/ staff training • Target intake for each resident to be noted on Fluid Balance Chart • Responsibility for assisting residents with fluid intake to be delegated to a specific Care Assistant • Reinforcement of medicines management policy	These case conferences were examples of the NHSCT attempting to improve the standard of care in CTH. However, there is little evidence that these issues were adequately addressed during the next inspection by RQIA on 11/05/2010. Inspection Chronology (No.30).
45 C	<u>15 March 10</u> Anonymous complaint (now known to be WB) made to Northern Ireland Human Rights Commission in respect of care in	NHSCT NIHRC PSNI RQIA	Following a trust multi-disciplinary meeting which included PSNI and RQIA 26/03/10 the NIHRC was advised that	Refer to Whistleblowing Chronology (No 28). The review team note that in the minutes of the meeting 26/03/10 many of the assurances given in

	Complaint/ Untoward Incident	Organisations involved	Outcome	Review Team's Findings/Gaps
	CTH. e.g. personal care, moving and handling, management of aggression, medicines management, restraint of residents, hygiene standards.		the sexual abuse allegations had been investigated previously and were unsubstantiated. Other care issues had been investigated and "there was no evidence to corroborate them" RQIA advised that an inspection in January 2010 had not raised any major concerns.	respect of these allegations were from the CTH manager. Next inspection was 11/05/2010 Inspection Chronology (No 30). No evidence that continence care/ toileting schedules have been reviewed in this inspection or in any inspections despite this being a recurring theme raised by WB in this complaint or previous complaints 42, 44 and 45.
46 C	<u>16 April 10</u> Letter from CTH staff member to RQIA re security and fire safety issues	RQIA	RQIA Complaints manager responded and advised complainant to raise complaint with CTH. This was reviewed during the next care inspection on 11/05/2010. Inspection Chronology (No 30).	The next Estates inspection on 20/08/2010 did not follow up on security or fire risks in respect of this incident.
47 C	<u>11 May 10</u> Anonymous complaint to RQIA by a member of staff. Issue of staff shortages, physical and verbal abuse, pages ripped out of complaints book in CTH.	RQIA	Unannounced inspection had already been planned for this day.	Refer to Whistleblowing Chronology (No 29). Inspection Chronology (No 30).

	Complaint/ Untoward Incident	Organisations involved	Outcome	Review Team's Findings/Gaps
48 C	13 October 10 Anonymous letter to RQIA re care issues e.g. safety, security of residents, food, recreation, risk assessments, staff morale re management.	RQIA	Unannounced Inspection planned for 25&26/10/2010. Inspection Chronology (No 32). There is evidence that many of the issues raised were reviewed during the inspection.	Refer to Whistleblowing Chronology (No 31).
49 C	25 November 10 Family member emailed RQIA re a Care Assistant's behaviour.	RQIA NHSCT	Meeting with Trust and CTH staff with complainant on 7/01/2010. Permanent placement team review on 21/01/2010 of resident's care.	Evidence of NHSCT reminding the CTH manager to have a process to ensure all complaints are recorded and investigated. There is no mention of complaint issues noted in the report of the review meeting.
50 UI	8 December 10 Allegation of 2 residents assaulting one another.	RQIA NHSCT PSNI	Safeguarding meetings PSNI involved 12/01/2011. CTH Proprietor eventually issued one resident, the initial	Review team believe that significant time was spent on this issue to try to seek resolution. Whistleblowing Chronology (35 and 52) Of particular note was a meeting on

	Complaint/ Untoward Incident	Organisations involved	Outcome	Review Team's Findings/Gaps
			alleged victim, with a 28 day notice to leave CTH on 20/03/2011.	7/03/2011 where NHSCT clearly held CTH management / registered provider to account for actions in relation to quality of care within CTH. This represented a robust challenge to CTH by the Trust.
51 C	15 February 11 Telephone call from WB to RQIA re abuse to a resident by a Care Assistant.	RQIA PSNI NHSCT	RQIA contacted NHSCT for the matter to be investigated under the Safeguarding Vulnerable Adults procedure. NHSCT contacted PSNI who investigated and found that no assault had taken place.	Policies and Procedures followed. Whistleblowing Chronology (No 35).
52 C	17 February 11 Letter from resident regarding attitude of Care Assistant.	NHSCT	Care Assistant was suspended by CTH registered provider on 21/02/2011 and was dismissed on 6/07/2011.	The review team believes this to be the main WB. Whistleblowing Chronology (No 36).
53 C	22 February 11 Family member contacted RQIA re a resident concerning standards of care including personal care and dehydration.	RQIA	RQIA advised complainant to raise with CTH and if not satisfied raise with NI Ombudsman for Complaints.	Review team unaware if this was pursued by the complainant. However it is noted that the issues were not reviewed again at the next inspection on 20/04/2011 due to other pressing matters. Inspection Chronology (No 34).

	Complaint/ Untoward Incident	Organisations involved	Outcome	Review Team's Findings/Gaps
54 C	6 June 11 Family member complaint to BHSCT re standard of care including Staff attitude/ theft/ toileting issues/ environmental cleanliness.	BHSCT NHSCT	Trust asked CTH to investigate and report back on issues identified. Report submitted to Trust rejecting most of the issues complained about. Resident moved by family to another home.	Policies and Procedures followed Review team met with family who remain dissatisfied with the outcome of the investigation.
55 C	9 June 11 NHSCT member of staff contacted RQIA re concerns re absence of manager and deputy in CTH and competence of staff left to manage home.	NHSCT RQIA	RQIA conducted an inspection the following day which focused on staffing levels. Feedback to NHSCT following inspection.	NHSCT were proactive in respect of concerns in CTH. Prompt action by RQIA. Good interagency working. Inspection Chronology (No 36).
56 C	24 July 11 Letter from a GP (6/10/2011) in Out of Hours service regarding a visit to CTH on 24/07/2011 re very poor standards of care and communication while GP was visiting. RQIA informed on 3/12/ 2012 by CTH.	RQIA Out of Hours service	RQIA followed up when they were made aware of the complaint and requested a report from CTH. This was received. CTH investigated the complaint in December 2012 and substantiated most of the allegations made by the GP. It was also noted that the resident's own GP had concerns "regarding	RQIA noted with concern how CTH had managed this complaint especially the time lapse in reporting and dealing with this complaint (14 months later).

	Complaint/ Untoward Incident	Organisations involved	Outcome	Review Team's Findings/Gaps
			availability of information and having appropriate staff present during home visits".	
57 C	6 Oct 11 Visitor to CTH made a complaint re physical and verbal abuse from a Care Assistant to resident.	NHSCT	Care Assistant suspended on 7/10/2011. Investigation carried out. Allegation was not substantiated as Care Assistant was not on duty that particular day. Care Assistant reinstated.	
58 C	9 November 11 Resident made allegation of physical and verbal abuse by Care Assistant.	NHSCT	Investigated by CTH. Allegations not substantiated. NHSCT requested copy of the investigation report.	Despite repeated requests from the NHSCT for CTH to provide a copy of the inspection report. The review team saw no evidence that the report of the investigation was provided to NHSCT.
59 UI	17 November 11 Incident reported re resident falling from a wheelchair.	RQIA	Investigation was conducted and the Care Assistant was given a final written warning on 16/01/2012.	

	Complaint/ Untoward Incident	Organisations involved	Outcome	Review Team's Findings/Gaps
60 C	23 January 12 Family member raised complaint during a NHSCT Care Review meeting that a Care Assistant refused to assist resident with toileting and personal hygiene.	NHSCT	Investigation was carried out by CTH and the complaint was not substantiated.	
61 UI	20 February 12 Incident involving resident falling from hoist while being transferred from chair to bed.	RQIA	Investigation by CTH. Care Assistant noted in No 57 and 59 above was suspended on 20/02/2012 and resigned on 6/03/2012 before the disciplinary hearing took place.	The review team note that NHSCT advised the registered provider of CTH to report named staff to NISCC.
62 C	18 May 12 Allegation of verbal abuse by a Care Assistant to a resident reported by a visitor to CTH.	NHSCT	Care Assistant was suspended on 18/05/2012 pending investigation. Allegation was not substantiated. Care Assistant reinstated and additional training offered.	
63 UI	24 July 12 Alleged theft from resident's bank account	NHSCT PSNI RQIA	Resident decided not to make a complaint to PSNI as suspect was a family member.	Policies and Procedures followed.

	Complaint/ Untoward Incident	Organisations involved	Outcome	Review Team's Findings/Gaps
64 UI	18 September 12 Incident of physical assault by nurse on resident while administering drugs.	NHSCT PSNI Nursing Agency	Resident did not wish to proceed with the PSNI investigation.	Policies and Procedures followed.
65 C	17 January 13 Letter by family member to CTH Proprietor. Refusal by CTH to take resident back from hospital. Also concerns re dignity and respect, environmental cleanliness / soiled linen left from resident's transfer to hospital in December 2012.	C Ex NHSCT RQIA NI Ombudsman	Response letter from NHSCT C Ex stated that complaint would be forwarded to appropriate Trust person. It was expected that CTH would deal with the complaint.	Review team met with family who remain dissatisfied with all organisations involved in dealing with complaints. They stated that they felt they were sent "from pillar to post" by different organisations with no one willing to take responsibility. They also wished to stress the lack of, or poor, communication in relation to raising concerns with the authorities. One year on, they reported no feedback from CTH to their complaint.

3.4 Summary of Review Team's Findings

An analysis of the 65 complaints and untoward incidents in the above chronology identified the following areas of concern. The numbers in brackets set out the incidence of each issue.

Allegations of abuse:

- Allegations of abuse by staff (12)
- Allegations of abuse by a resident against other residents (7)

Personal care in respect of individual residents:

- Poor care standards (4)
- Poor nutrition / weight loss (5)
- Lack of privacy and dignity (3)
- Pressure sores (3)
- Lack of medical attention (3)
- Continence care (3)
- Dehydration (3)
- Neglect (1)
- Misuse of bed rails (1)
- Shortage of Laundry (1)

Other care issues:

- Falls (10)
- Poor level of hygiene in home (8)
- Loss / theft of residents' property (6)
- Management of medicines (5)
- Lack of activities for residents (2)
- Poor communication with families (2)
- Fire safety concerns (2)
- Issues with care records (2)
- Health and Safety concern (1)
- Poor management of aggression (1)
- Moving and handling problem (1)

Staffing:

- Poor staff attitudes (8)
- Inadequate staffing levels (5)

3.5 Response of External Organisations to Complaints and Untoward Incidents

This section deals with the summary of findings based on the documentary evidence made available to the review team in respect of external organisations handling of complaints and untoward incidents.

3.5.1 Northern Health and Social Care Trust

The majority of residents in Cherry Tree House reside within the NHSCT geographical area. This means that the NHSCT had to deal with most of the complaints examined by the review team.

The review team noted with concern that, in September 2006, a member of Trust staff was reported to have said to RQIA that her team was not investigating complaints in Homes due to time restraints. However, we found no evidence of such constraints from that time onwards.

The review team has concluded that NHSCT staff dealt with most complaints in a timely and appropriate manner. The trust initiated investigations and meetings under the Safeguarding of Vulnerable Adults procedures and in respect of a number of complaints, the Trust initiated inter-agency safeguarding investigations. The minutes of some of the safeguarding strategy meetings did not record who was to be interviewed as part of the investigation record.

The review team noted that on many occasions the Trust relied on the outcome of internal investigations by Cherry Tree House management to provide them with assurance of the standard of care provided. This was consistent with the provision of Circular HSC (SQSD) 23/2009 (Ref page 6) which provided for local resolution of a complaint.

The review team noted that on occasions, NHSCT staff attempted to hold the registered provider and manager to account for actions in relation to the quality of care and handling of complaints within Cherry Tree House. The following meetings represented robust challenges to Cherry Tree House by the Trust;

- On 7 March 2011, following the investigation of a complaint of the assault of a resident by another resident (Complaint Chronology No 50), the Northern Trust held a meeting with Cherry Tree House about this complaint and other matters that were causing concern. The review team note that this resident was given notice to leave Cherry Tree House a few days later.

- On 22 March 2011 senior Trust staff met with Cherry Tree House registered provider and manager to clarify the Trust's expectations in respect of securing appropriate placements; monitoring, delivery and quality of care; ensuring complaints and incidents were being addressed appropriately; and protection of vulnerable adults. The

Trust expected Cherry Tree House to provide good standards of care; respond to complaints and incidents; feedback responses to complainants; report issues to Trust; and work collaboratively with the Trust to address issues.

It was also noted that the Trust was proactive in ensuring that Cherry Tree House management reported 2 members of staff to the appropriate regulatory authorities.

- a nurse manager was reported to the NMC
- a care assistant was reported to the NISCC (Complaints Chronology No 61)

The review team noted that at the hearing of the Nursing and Midwifery Council on 19-21 February 2014, the nurse manager was suspended from the Nursing and Midwifery Council Register with opportunity to appeal this decision within 18 months.

3.5.2 Belfast Health and Social Care Trust

As mentioned previously, the majority of residents of Cherry Tree House reside in the NHSCT area. However, a number are from the BHSCT area.

The review team noted that only 3 complaints and untoward incidents related to BHSCT residents and there is evidence to demonstrate that the BHSCT dealt with these in a timely and appropriate manner. For example, in respect of an untoward incident in 2008 (Complaints Chronology No 28), the Trust's contract monitoring department was not content with the initial response from Cherry Tree House and sought, and received, a follow up report from Cherry Tree House.

The male resident at the centre of the allegations of sexual abuse that were first made by WB to the Chair of the Health Committee in April 2009, and referred to in subsequent allegations, was a Belfast resident. There is evidence that the Trust participated in the safeguarding investigations that ensued. It also was able to confirm to the DHSSPS at that time, that there were no concerns about the safety of the other eight Belfast residents who were resident in Cherry Tree House at that time.

3.5.3 Police Service of Northern Ireland

The PSNI was involved on a number of occasions with Cherry Tree House over this period, for example, in respect of investigating thefts and sightings of youths trespassing in the grounds of Cherry Tree House. Of note was the theft of controlled drugs in January 2007 which was investigated by the PSNI. The investigation concluded that no suspects were identified.

On receipt of allegations of historical abuse made to the Chair of Health Committee in 2009 and to the Northern Ireland Human Rights Commission in 2010, the PSNI was actively involved with other agencies in attending safeguarding meetings and conducting investigations. The PSNI reported that there was insufficient detail to investigate these allegations and they could not be substantiated.

There was evidence that the PSNI supported any requests for their involvement in allegations and actively collaborated with other agencies as the need arose.

3.5.4 The Regulation and Quality Improvement Authority

It should be noted, as referenced in section 3.1 above, that over the period of this review, RQIA's responsibilities in respect of complaints changed. From April 2009, RQIA was no longer responsible for investigating complaints that had not been resolved at a local level (i.e. by Cherry Tree House or the Trust). From that date, RQIA has been responsible for overseeing how Trusts and homes implemented the DHSSPS complaints procedure.

In 2006 and 2007, RQIA conducted 4 complaints inspections, to monitor issues concerning the quality of care to named residents and to examine how Cherry Tree House managed these complaints. The seriousness of the issues raised required an inspection to be carried out. All of these inspections resulted in requirements and recommendations being made to improve the care provided in the home.

The review team found that in general, RQIA responded promptly to complaints and untoward incidents. The following is an example of good practice:

- Following receipt of an anonymous complaint (Complaint Chronology No 22) regarding staffing levels and health and safety concerns, RQIA carried out a Complaints Inspection on 6th April 2007 (Inspection Chronology No 15). At this inspection, RQIA found that there were deficiencies in staffing levels and subsequently suggested to the NHSCT that there should be a temporary suspension of admissions to Cherry Tree House. This suspension lasted for 3 weeks and was lifted following an unannounced Care Inspection on 24th April 2007.

However, in respect of 11 events, although the complaint or untoward incident was dealt with, there was no evidence that the issues of concern were raised at the next appropriate inspection.

3.5.5 Interagency working

The review team believe that in general there were examples of good interagency working in respect of organisations dealing with complaints and, where appropriate, the investigation of untoward events. Examples include:

- In May 2006, RQIA was contacted by a family member concerned about the care of her mother in Cherry Tree House (Complaint Chronology No 18). The RQIA inspector advised the caller to raise her concerns at the review of her mother's care that was due the following week. The inspector also contacted Trust staff to inform them of these concerns. Further contact between RQIA and the Trust after the review meeting confirmed that the matters had been discussed and resolved to the concerned daughter's satisfaction.

- On 7 February 2013, staff of NHSCT and RQIA met to discuss ongoing concerns about Cherry Tree House and actions being taken to resolve these.

3.6 Views of Families and Others who had reported concerns

Those who had made complaints, and who met with the review team, expressed concerns regarding how their complaints were handled. They were particularly critical of Cherry Tree House handling of their complaints.

All of those whom we met, stated that they had not received information explaining how to make a complaint when the relative was first admitted to Cherry Tree House nor did they know how to progress a complaint. In addition, they did not understand the different roles of the Trust, RQIA, the Patient Client Council and the N.I. Ombudsman or indeed the various procedures to be followed.

Some reported that, when they made a complaint, they felt that they were being passed from one organisation to another with no one “willing to take responsibility”.

Of concern was their interpretation of how investigations into their complaints were handled. Family members told us that they had not been part of the investigation into their complaint. They also said that care staff, who could have informed the investigation, were not interviewed. This was confirmed by former staff with whom we met.

All felt that external investigations placed an over-reliance on reports made by the management of the Home. In the words of one relative, the trust and RQIA, “ask management to investigate themselves and write a report”.

Families were especially dissatisfied with the amount and quality of feedback to their complaints. In some instances, where a resident had left or had been asked to leave Cherry Tree House, families expressed disappointment that complaints remained unresolved.

Some families felt that, having raised a complaint, the management of Cherry Tree House regarded them as “troublemakers”.

3.7 Comments and Recommendations

The review team's findings, based on the written evidence of the 65 complaints and untoward incidents, indicate that, with some exceptions, procedures were followed by the Trusts, RQIA and the PSNI. There was also evidence of good inter-agency cooperation.

The review team has identified the following shortcomings in the handling of some complaints and untoward incidents.

- The minutes of some vulnerable adult strategy meetings did not identify those to be interviewed during the investigation.

- In some instances, RQIA did not follow up on the issues raised in complaints in the next inspection of the home (also section 4.7).

Recommendations

Following consideration of the written evidence and the views of families and others, the review team makes the following recommendations.

1. The regional contracts for residential and nursing home care should be amended to require homes to report each complaint, to the relevant trust, about the care of patients / residents and the outcome of the internal investigation.

2. Trusts should ensure that there is a mechanism for communicating such complaints to those trust staff who are responsible for reviewing the care of residents.

3. Trusts should seek assurance at their contract review meetings with homes, that for the complainant all complaints issues have been addressed.

4. In order to improve the accessibility and quality of Information about making a complaint, the following should be considered:

    - Trusts' information packs for prospective residents and their carers should include details of how to make a complaint;

    - New residents and their families should be provided by homes with information on making a complaint. Such information should be both in the admission pack and on display in the home; and

    - All information, regardless of source, should include reference to the role of the Patient Client Council in providing support and advice to complainants.

5. The quality of investigations should be enhanced by investigators:

    - Speaking to the complainant to clarify the issues of concerns; and

- Interviewing all care staff who might be able to contribute to the process.

6. Vulnerable Adults strategy meetings should clearly identify those individuals who need to be interviewed.

7. All organisations should ensure feedback to complainants is accurate and timely. They should seek assurance that the complainant is satisfied with the handling of their complaint.

4.0 Whistleblowing

This section outlines whistleblowing legislation and policy and delivers a chronology of whistleblowing events and the experience of whistleblowers, especially the main whistleblower between March 2006 and March 2013 in respect of Cherry Tree House. It summarises the issues raised by whistleblowers and describes the responses of the relevant organisations. In addition, it provides an account of the views expressed by whistleblowers and their representatives to the review team. The section concludes with recommendations.

4.1 Legislation

The relevant legislation is the Public Interest Disclosure (Northern Ireland) Order 1998 which became law on 31 October 1999.

The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 23 (1) and (2)[3] states:

"(1) This regulation applies to any matter relating to the conduct of the nursing home so far as it may affect the health or welfare of patients.

"(2) The registered person shall make arrangements to enable staff to inform the registered person, and the Regulation and Improvement Authority, and the HSC Trust in the area of which the nursing home is situated, in confidence of their views about any matter to which this regulation applies."

Nursing Homes Minimum Standards (2008) Standard 25 (20) and (21)[4] states:

"(20)There is a written policy on "Whistle Blowing", and written procedures that identify to whom staff report concerns about poor practice.

"(21) There are appropriate mechanisms to support staff in reporting concerns about poor practice."

4.2 Whistleblowing in Health and Social Care Organisations

The role of whistleblowing in HSC organisations over recent years has been significant in many high profile cases where a lapse was identified in the quality of care provided to patients and clients.

It is now accepted that risk within an organisation is often recognised first by people who work in, or with that organisation. Legislation, policies and procedures and guidance are in place across the United Kingdom (UK) to protect workers who 'blow the whistle'. We note that the relevant legislation,

[3] http://www.rqia.org.uk/publications/legislation.cfm

[4] http://www.rqia.org.uk/publications/useful_documents.cfm

however, does not require organisations to have a whistleblowing policy, but encourages them to do so.

Public Concern at Work was established in 1993 as a charity to promote and publicise the role of whistleblowing within accountability and governance arrangements. It subsequently set up a Whistleblowing Commission in February 2013 to examine the effectiveness of existing workplace whistleblowing arrangements across the UK and make recommendations for change.

"Effective whistleblowing arrangements are a key part of good governance. A healthy and open culture is one where people are encouraged to speak out, confident that they can do so without adverse repercussions, confident that they will be listened to, and confident that appropriate action will be taken. This is to the benefit of organisations, individuals and society as a whole"[5]

Workplace whistleblowers are legally protected[6] if they act in good faith, have a reasonable belief that the information or allegation is true and make the disclosure to the correct or appropriate (specified) person. The Department of Employment and Learning (DEL) has produced a guide to this legislation.[7] This defines what can be disclosed and the circumstances in which disclosures are protected.

Circular HSS (GEN1) 1/2000 was issued by DHSSPS on 14 January 2000 to inform the service about the Public Disclosure Order which had become law in October 1999. It noted that there "should be a culture and environment everywhere in the HPSS which encourages staff to feel able to raise concerns about health and social care matters sensibly and responsibly without fear of victimisation". The circular also identified actions which HPSS bodies should take in response to the legislation.

DHSSPS issued Circular HSS (F) 07/2009 on Whistleblowing on 17 February 2009, "to encourage HSC bodies to ensure they have whistleblowing procedures in place and make accounting officers aware of a template which has been drawn up for use in developing organisational specific arrangements". This was issued in response to a Department of Finance and Personnel letter to Accounting Officers on 6 November 2008.

On 22 March 2012, the Minister wrote to the HSC highlighting the importance of whistleblowing and encouraging staff to come forward to him with issues of genuine concern which they believe are not being addressed locally. In his letter the Minister concludes, "Finally I would like to encourage you to feel confident in raising concerns and to question and act upon genuine concerns that you may have in relation to your workplace. This is a vital element of good public service based on the values and principles that are at the heart of Health and Social Care and all related organisations."

[5] Foreword to 'Report on the effectiveness of existing arrangements for workplace whistleblowing in the UK', The Whistleblowing Commission, November 2013.
[6] Public Disclosure (Northern Ireland) Order 1998; Public Interest Disclosure (Prescribed Persons) (Amendment) Order (Northern Ireland) 2012.
[7] Guide to the Public Disclosure (Northern Ireland) Order 1998; Amended October 2012.

4.3 Whistleblowing about Cherry Tree House

The chronology that follows identifies each of 55 whistleblowing issues, and the experience of whistleblowers which were considered by the review team. It highlights each issue or event by date, identifies the organisations involved, any outcomes achieved and briefly summarises the findings of the review team. The chronology begins on 2 March 2006 and ends on 1 March 2013 and includes matters drawn to the attention of:

- Cherry Tree House
- RQIA
- NHSCT
- DHSSPS
- Northern Ireland Human Rights Commission
- Northern Ireland Ombudsman for Complaints

A significant number of these events related to the actions of one whistleblower to whom we refer as "WB" in this report. WB raised her concerns with political representatives and public bodies throughout the period reviewed. These communications and meetings resulted in her concerns and allegations being shared with other agencies for investigation.

In addition, the chronology describes the journey of WB and the difficulties she encountered in her attempts to raise concerns about the quality of care and safety for residents in Cherry Tree House.

There were other whistleblowers who expressed concerns about care at Cherry Tree House:

- An agency Care Assistant (Whistleblowing Chronology No1)
- Three Care Assistants on night duty - including WB (Whistleblowing Chronology No 4)
- Three members of Cherry Tree House staff (Whistleblowing Chronology No 27)
- "An Observer, Carrickfergus" (Whistleblowing Chronology No 30)
- A member of Cherry Tree House staff (Whistleblowing Chronology No 39)
- A member of Cherry Tree House staff (Whistleblowing Chronology No 55).

4.4 Chronology of Whistleblowing events and experiences of WB and others

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
1	2 March 06 Anonymous phone call to RQIA from an agency Care Assistant	The whistleblower alleged that home had been short staffed overnight and residents did not receive adequate care. Issue re a resident falling. RQIA	RQIA contacted CTH manager. Investigation carried out. Response sent to RQIA on 7/03/2006. RQIA satisfied with CTH response to complaint from whistleblower.	Refer to Complaints Chronology (No16).
2	16 March 06 Anonymous letter from staff member WB to Chief Inspector Social Services DHSSPS	Concerns re: • Abuse and neglect • Treatment of overseas workers • Top up fees • Relatives being talked about by the manager • Urine stained mattresses • Oil cloth on the floor • Cracked toilet • Storage of drugs • Viagra in Home • RQIA inspectors letting Manager sit in on interviews with staff during inspections • Over familiarity of	RQIA carried out a complaints inspection on 20/03/2006 Inspection Chronology (No 6) Unannounced inspection 30/04/2006 i.e. 6 weeks later. Some issues raised by WB examined. RQIA report in respect of inspection on the 20/03/2006 "was delayed" no date noted on the report or covering letter. "Whilst the majority of issues were not substantiated, there were a number of areas where improvement could be	Prompt action by RQIA. However there is no evidence that RQIA subsequently sought assurance that CTH had implemented the improvements identified following their inspection.

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
		inspectors with manager • RQIA failure to detect or uncover concerns DHSSPS RQIA	made" i.e. introduce resident meetings/ introduce terms and conditions of residency / further detailed cleaning of toilet areas and refurbishment of toilets and bathrooms.	
3	5 May 06 Letter from RQIA to WB offering to meet as result of complaint	Meeting held in relation to issues raised above. RQIA	Meeting held on 5/05/2006 with WB and a previous employee of CTH and the Director of Nursing and Regulation.	No RQIA note of this meeting was made available to review team.
4	21 May 06 Letter to CTH manager signed by 3 Care Assistants (including WB).	Concerns on night duty re: • Poor standards of care • Poor communication between staff • Toileting needs of residents not being met during the day/ toileting records attached	Outcome to letter not known.	Review team has no evidence that these issues were raised with other organisations at this time. However they became aware of them following a meeting of WB with Chair of Health Committee on 23/04/2009.

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
5	November 06 - January 07 WB's personal record	Acting manager had been told over this period the names of residents who were being abused by a male resident. WB records actions on 14/12/2006 re how the staff tried to manage the associated risks with the male resident in respect of female residents.	Outcome to letter not known	Review team has no evidence that these issues were raised with other organisations at this time. However organisations became aware of them following a meeting of WB with Chair of Health Committee on 23/04/2009.
6	31 August 07 Letter to CTH manager from Night Duty Care Assistants	Concern of staff over lack of support and help from some care assistants and nurses on night shifts.	Outcome to letter not known	Review Team has no evidence that these issues were raised with other organisations at this time. However they became aware of them following a meeting of WB with Chair of Health Committee on 23/04/2009.
7	14 October 08 Letter from WB to CTH manager	Letter raised concerns of abuse to residents: State of Resident's wheelchair/ covered in urine When WB came on duty that night resident's trousers were very wet with urine.	Outcome to letter not known	Review team has no evidence that these issues were raised with other organisations at this time. However organisations became aware of them following a meeting of WB with Chair of Health Committee on 23/04/2009.

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
		Resident stated she hadn't been taken to the toilet all day. Toileting schedule confirmed this and a copy was attached to the letter.		
8	16 October 08 Telephone call to RQIA from WB	WB contacted RQIA to raise a number of concerns. These included: • Bed rail entrapment • Environmental cleanliness • Poor moving and handling practices i.e. not using hoists • Falsification of records. • Continence management issues RQIA NHSCT	RQIA requested CTH to undertake an investigation. CTH manager advised that allegations were not proven. RQIA accepted this. WB advised of outcome and thanked RQIA in telephone call, 17/11/2008, for 'progressing the matter'. WB did however note an improvement following raising concerns.	While CTH manager stated everything was in order, RQIA did challenge this. The next inspection on 8/1/2009 made no reference to these allegations. Inspection Chronology (No 23).
9	3 November 08 Letter to CTH manager from WB	Concerns re rough handling of residents by some staff. RQIA advised on 17/11/2008	RQIA requested an investigation. Report received on 28/11/2008. Allegations denied by residents.	

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
10	11 November 08 CTH manager	CTH manager advised RQIA that a member of staff would be in contact to make allegations of historical abuse. (noted in a letter dated 7/05/2009). RQIA PSNI NHSCT		The review team note that WB made allegations of historical abuse to the Chair of the Health Committee on 23/04/2009.
11	11 December 08 Letter from CTH manager to WB	CTH manager requesting WB to provide a statement in relation to her allegations of abuse. Manager also advised that she would arrange a meeting with WB re the issues.	WB provided statement on the 15/12/2008. However there was no evidence that a meeting took place as promised.	Review team saw no evidence of response. WB met with the Chair of the Health Committee on 23/04/2009.
12	15 December 08 Letter/ statement from WB to CTH manager	Detailed statement with names and accounts of incidents of abuse and action taken by WB to protect residents.	Outcome not known.	
13	30 December 08 Personal record of WB	A Care Assistant told WB that she and another Care Assistant had sent letters to CTH manager re the male resident and his behaviour towards staff.	Outcome not known.	The review team understands that other organisations only became aware of these issues after WB met with the Chair of the Health Committee on 23/04/2009.

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
14	January / February 09 Personal record of WB	Concerns re voluntary worker with no training working in the home and giving personal care.	Outcome not known.	The review team understands that other organisations only became aware of these issues after WB met with the Chair of the Health Committee on 23/04/2009.
15	5 January 09 Personal record of WB	WB records that a nurse advised that a male resident had made a sexual comment to her on 1/01/2009-she couldn't repeat it as it was so offensive. The nurse had "handed it over at the report on Friday 2/01/2009."	Outcome not known.	The Review Team understands that other organisations only became aware of these issues after WB met with the Chair of the Health Committee on 23/04/2009.
16	5 January 09 Letter to CTH manager from WB	WB raises concerns re a resident not being toileted for a prolonged period. Evidence provided in toileting schedule 20/01/2009. Similar concerns were recorded by WB in the communication book.	Outcome to letter not known.	The review team understands that other organisations only became aware of these issues after WB met with the Chair of the Health Committee on 23/04/2009.

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
17	6 January 09 Copy of WB's Annual Personal Appraisal Form	WB notes concern re abuse in CTH. Requests to have staff meetings, to see RQIA inspection reports and NVQ training.	Outcome to request not known.	Evidence of WB raising concerns locally in CTH.
18	13 April 09 Personal record of WB	WB states she reported residents fighting and again the same issue on the 27/04/2009	Outcome not known at this time.	The review team understands that other organisations only became aware of these issues after WB met with the Chair of the Health Committee on 23/04/2009.
19	21 April 09 Personal record of WB	WB writes that care assistant was offended by male resident's comments. WB asked if care assistant had reported the matter and she replied; "No what's the point nothing is ever done about it anyway."	Outcome not known at this time.	The Review Team understands that other organisations only became aware of these issues after WB met with the Chair of the Health Committee on 23/04/2009.
20	23 April 09 Letter from Chair of Health Committee to the Minister	WB met with Chair of Health Committee and advised her of historical abuse dating back to 2007 in CTH. In addition WB provided evidence of poor quality of care and communication issues.	1. DHSSPS contacted the NHSCT and RQIA re letter from Chair of Health Committee and requested that all relevant safeguarding protocols were to be initiated. All supporting documentation was given to RQIA at the	The review team noted good interagency working. The review team did not review any evidence in respect of feedback to WB. At a meeting with the review team, WB confirmed she had no

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
		A letter was sent from the Chair of the Health Committee to the Minister requesting that the allegations should be investigated. Minister DHSSPS PSNI NHSCT BHSCT RQIA	same time. 2. DHSSPS sought assurance from the NHSCT and BHSCT that the safety of residents would be reviewed in light of these allegations. This assurance was subsequently given in letters to the DHSSPS. 3. Safeguarding Strategy Meeting with PSNI and Trust staff was held on 1/05/2009 to discuss how to proceed with the investigation. 4. Safeguarding Review Meeting on 3/07/2009 noted that the allegations of abuse could not be substantiated. 5. RQIA advised DHSSPS on 6/05/2009 that "the inspector would ensure that the care issues as identified in the correspondence would be examined during the inspection planned for May 2009".	feedback from this meeting with the Chair of the Health Committee. This inspection report Inspection Chronology (No 26) makes no reference to the issues raised by WB.

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
21	27 April 09 Personal record of WB	"(Care Assistant) stated to me that (male resident) is now after (a different female resident)." Care Assistant had told WB a family were so concerned about a resident having cot sides dropped on her leg, they moved her from CTH. A nurse used the wrong hoist sling, and a resident fell through it. Report of incident ripped from diary.	Outcome not known at this time.	This evidence was subsequently made available to relevant trust. Review team cannot be definitive as to when this happened.
22	29 April 09 - 6 May 09 Personal record of WB	WB wrote a letter to CTH manager and recorded concerns on home's communication book: • resident trapped in bed rail • overcrowding in the alcove area and associated fire risks. • residents becoming agitated and fighting	Outcome unknown.	At the subsequent inspection on 14/05/2009 Inspection Chronology (No 26) the issue of bed rail entrapment was raised by RQIA. There is no reference in inspection reports that the management of continence was reviewed.

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
		• unacceptable state of resident - "swimming in their own urine and faeces for hours". • no record in toileting schedules that residents had been toileted.		
23	11 May 09 Letter to CTH manager from WB	Concern re resident found in an unacceptable state / pad so wet / trousers wet through / toilet schedule not recorded all day.	Outcome to letter not known.	This evidence was subsequently made available to other organisations. Review team cannot be definitive as to when this happened.
24	24 June -1 July 09 Letter from WB to CTH manager. Telephone call noted from WB to RQIA. Letter to CTH registered provider from WB. Letter from registered provider to RQIA.	WB contacted RQIA to report verbal abuse which happened on the 23/06/2009. WB advised she had written to the CTH manager on 29/06/2009. RQIA advised WB to contact CTH owner. Letter included statement re incident on the night of	RQIA contacted registered provider and advised of conversation with WB. Requested CTH to report back actions the following day. Local investigation conducted in CTH following request by RQIA. Care Assistant was dismissed on	Complaints Chronology (No 41).

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
		23-24 June 2009. Safeguarding meeting 5/11/2009. RQIA NHSCT PSNI	10/11/2009. Care Assistant was suspended on 3/07/2009 and dismissed on 10/11/2009.	
25	3 July 09 Letter from NHSCT to CTH manager.	Issue of WB breaching confidentiality and taking of photographs discussed in respect of incident on 24/06/2009. Also concern about WB typing up records at her own home. CTH manager advised that WB was being changed to day duty rota. NHSCT		Refer to No 26 below.
26	18 August 09 WB's notes of meeting with CTH manager	Evidence of CTH manager challenging WB re reporting issues regarding lack of toileting of residents.	WB advised of move to day duty. WB informed manager that, given child minding issues, she needed time to make suitable arrangements.	WB reported feeling intimidated by manager.

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
27	11 November 09 Letter of complaint to RQIA from 3 whistleblowers.	Complaint re 2 residents receiving preferential treatment in CTH RQIA	Investigated by CTH manager. RQIA raised concern that the manager investigated a complaint in which she was implicated. Registered provider was requested to provide assurance of satisfaction with the rigour of the investigation.	Evidence that RQIA pursued issue until it was satisfied that the matter had been investigated appropriately. Refer to Complaints Chronology (No 43).
28	15 March 10 E mail from C Ex NIHRC to C Ex of NHSCT It is now known that WB made the complaint to NIRHC.	Anonymous complaint to NIHR Commission in relation to abuse: • residents being left soiled all day • failure to routinely hoist residents • medicines management issues • residents strapped into chairs for 14-15 hours each day • poor hygiene BHSCT NHSCT PSNI RQIA	NIHRC was advised that the sexual abuse allegations had been investigated previously and were unsubstantiated. Other care issues had been investigated and "there was no evidence to corroborate them." RQIA advised that an inspection on 5/6 January 2010 had not raised any major concerns. Inspection Chronology (No 29). Refer to Complaints Chronology (No 45).	The review team note that most of the assurances given in respect of these allegations were from the CTH manager. (Complaint Chronology 45)

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
29	11 May 10 Anonymous call to RQIA. (Now known to be WB.)	WB wished to advise RQIA of a number of concerns: • staffing levels • abuse to residents • residents serving themselves tea • allegations of abuse • allegations that references to these issues have been ripped out of the CTH communication book RQIA	By coincidence RQIA inspector was on her way to do an unannounced inspection that day and was contacted by a colleague in RQIA to be advised of WB's Complaint / issues.	11/05/2010 Inspection chronology No 30 No evidence that continence care/ toileting schedules were reviewed in this inspection or in any inspection over the time frame despite this being a recurring theme raised by WB and complainants. The inspection report shows that some of these issues were addressed. There was no evidence that the Inspector reviewed the CTH communication book.
30	13 October 10 Carrickfergus Observer Community member	Letter to RQIA raising the following concerns: • Registered status of home • Rigour of risk assessments • Safety and security of residents • Outings for residents • Quality of food • Staff morale • Racial discrimination • Management issues	RQIA record that they had planned an unannounced inspection for 25/26 October 2010	There is evidence that many of these issues were checked at the inspection of 25/26 October 2010 Inspection Chronology (No 32).

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
		• Lack of staff meetings RQIA		
31	21 January 11 File note following telephone conversation with WB to RQIA	WB wished to report allegations of abuse by a Care Assistant. WB is concerned about CTH's policy on the protection of vulnerable adults. WB gave detailed accounts, with dates of incidents, of verbal abuse to various residents. WB raised her concerns with CTH management in writing on 3/01/2011 and she received a reply on 11/01/2011 stating that an investigation would be taking place. RQIA NHSCT	RQIA contacted NHSCT and suggested that the trust needs to follow up these allegations of abuse, especially in light of meeting with CTH managers on 11/01/2011 when they indicated they had no concerns re abuse by this Care Assistant. RQIA also suggested that the trust should review the communication book. Care Assistant was invited to a disciplinary meeting to be held on 7/03/2012 in respect of care issues. She wrote her resignation letter on 6/03/2012. She was referred to Safeguarding Authority on the 20/09/2012 and NISCC on 27/09/2012 by new CTH manager on the advice of NHSCT.	The review team saw no evidence that RQIA reviewed the communication book on inspections.

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
32	1 February 11 Telephone call from WB to RQIA	On 25/01/2011 WB had come on duty early and found 2 male residents who were to be kept apart, as agreed at Safeguarding Vulnerable Adults Case Conference 12/01/2011, one was outside the other's room. WB reminded 3 of the staff on duty of this requirement but none of them appeared to have been given this instruction. WB then wished to record it in the communication book, however it was missing. Later that evening the home's registered provider asked WB and a staff nurse where the communication book was. WB reported she felt intimidated. RQIA CTH	RQIA contacted the CTH manager on 1/02/2011 at 11.45am re staff not being aware of the arrangements regarding keeping the 2 men apart. CTH manager was advised to ensure that staff knew how to access accident forms.	

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
33	3 February 11 Grievance Letter from WB to Proprietor of CHT	WB raises issues in respect of how CTH registered provider and manager had spoken to her on 31/1/2011regarding the missing communication book. "At the end of my ordeal with you and **...** on 31/1/2011 I felt I was being disciplined because I recorded an incident regarding C/A in the carers' communication book..... I felt yours and ...'s manner towards me throughout our conversation had been abrupt, intimidating and unprofessional." RQIA	Letter in response on 4/02/2011 to the registered provider advising of action to discuss the matter with RQIA.	Evidence of tension between WB and CTH management.
34	17 February 11 RQIA file note	WB rang RQIA re concerns of abuse to residents by a care assistant. WB advised that she had informed the CTH Manager however she had not taken any action. WB now feels she is being bullied at work because of	17/02/2011 RQIA contacted NHSCT for the matter to be investigated under the Safeguarding Vulnerable Adults procedure. NHSCT advised they would contact PSNI.	RQIA member of staff was supportive and helpful to WB. Told her to contact RQIA again if any further concerns re CTH. Complaints Chronology (No 51).

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
		raising issues. However she is very concerned about the care of residents in CTH. RQIA NHSCT PSNI		
35	21 February 11 Record of investigation carried out by a relative of a resident	Relative's record was shared with organisations: NHSCT minutes of meeting 7/03/2011 with CTH manager and registered provider that RQIA were made aware of content of investigation Evidence in an email dated 10/03/2011 sent from RQIA inspector to Head of Regulation that RQIA did have a copy of this record of 21/02/2011 NHSCT RQIA CTH	The NHSCT convened a meeting on 7/03/2011 with CTH manager and registered provider. Went through range of issues including letter / investigation by resident's relative re staffing issues. This included asking why WB had been suspended as she was only trying to implement protection plan for the relative. RQIA inspector advised relative that she would follow up the issues raised in the record of 21/02/2011 at the next inspection, especially staff shortages, staff sickness being covered up and medicines	Refer to Complaints Chronology (No 50). The next inspection was 20/4/2011. These issues were not followed up due to nutritional concerns noted during the inspection. Inspection Chronology (No 34).

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
			management. A further meeting was convened by NHSCT on 22/3/2011 with CTH manager and registered provider to "share roles and responsibilities of the Trust; clarify the expectations that the NHSCT has of CTH and to identify how both could be satisfied." Issues around whistleblowing, complaints management, staff related issues were discussed and NHSCT staff offered support to assist CTH in managing the home.	Evidence of Trust working with CTH to address expectations, roles and responsibilities.
36	21 February 11 Letter to WB from CTH manager	Letter of suspension sent to WB, in relation to allegations of abuse to a service user, alleged bullying and harassment of staff members. NHSCT	WB was suspended on 21/02/2011 and dismissed on 6/07/2011.	Complaints Chronology (No 52).

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
37	11 March 11 WB telephoned NHSCT	WB requested NHSCT to provide feedback on the matters previously raised by her. Trust asked for WB to put her request in writing. Letter was then sent to NHSCT on 4/04/2011 by WB. Letter re issued by WB on 22/04/2011 as she had not received a response to her letter of 4/04/2011. NHSCT PSNI	4/05/2011 Reply to WB advising that the issue re resident was being investigated by the Principal Practitioner for Vulnerable Adults. The second issue re care assistant was being investigated by the Locality Manager for Mental Health. A second letter dated 4/05/2011 then stated that an investigation regarding the above had been completed and the allegation was not substantiated. Allegations in relation to the resident and historical abuse were not responded to.	WB was requesting feedback on issues, some of which she had raised over 3 years previously. Note that feedback to WB who was known to NHSCT and other organisations was not given and she had to proactively request it.
38	27 April 2011 Letter from WB to RQIA enclosing documents (which WB referred to as "Work Documents 1, 2 and 3) and requesting a meeting with RQIA. These documents	Very detailed statements from WB on: • Physical and verbal abuse to residents • Lack of managerial support • Abuse did not appear to be investigated by management or action	1. Record of meeting RQIA had with WB on 16/06/2011. WB was advised that RQIA did not have a role in investigating complaints 2. 17/06/2011 RQIA wrote	1. Given the extensive issues raised by WB, the review team was concerned that the RQIA file note of the meeting was brief and did not appear to reflect the seriousness of the issues raised. 2. The review team notes the

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
	covered the period August 2009 to April 2011.	taken. • Those who raised concerns felt bullied.	to NHSCT and copied WB's documents to them. 3 NHSCT responded to the documents provided by WB on 24/11/2011 in a document commenting on the allegations provided in WB's documentation. While NHSCT was aware of some issues and these had already been addressed with CTH, the Trust was not taking action regarding other historical issues that had not been reported by CTH management or WB to the Trust. Given the passage of time, any investigation would likely be inconclusive. The Trust is now working with the new manager in CTH to address the outstanding investigations.	comment by NHSCT to RQIA that they "do not have the resources to repeatedly address these issues." 3. Despite RQIA writing to NHSCT on 1/12/2011 advising that a further inspection was planned for "later this month", RQIA did not carry out an inspection until 12/6/2012 i.e 6 months later. The review team note with concern the delay in carrying out the planned inspection given the seriousness of the issues raised by WB.

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
39	5 September 11 Letter from a different whistleblower	Anonymous letter to RQIA Inspector who had previously inspected CTH complaining about new manager and how staff are treated. RQIA	This was addressed at the inspection on 6/09/2011. Allegation not corroborated.	
40	26 October 11 WB letter to NHSCT.	1. Apology for stating RQIA staff member was at a meeting when they were not. 2. Accuses staff in CTH withholding information or being untruthful in respect of care assistant abusing residents. There were other episodes of abuse which were not reported. Other areas of concern in this letter were in respect of erroneous statements made by CTH manager in respect of : • Staff training • Weekly wheelchair checks • Further evidence of abuse to residents by	Reply sent from NHSCT on 23/11/2011 - stating that due to confidentiality the Trust could not share information.	Given length of time WB had been raising concerns the review team believe that a follow up meeting with WB at this stage might have been helpful.

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
		a care assistant WB advised she will now go to NI Ombudsman as she has sufficient information to show that vulnerable persons are at risk and authorities are not acting as they should.		
41	11 November 11 WB wrote to NI Ombudsman cited in letter to C Ex NHSCT dated 19/01/2012 (No 44 below).	WB relays concerns and frustrations to Ombudsman re apparent lack of action by various organisations in relation to care concerns. NI Ombudsman	WB reports that Ombudsman advised that her complaint had to be progressed by the NHSCT.	
42	19 January 12 Letter from WB to C Ex NHSCT	Following communication with Ombudsman, (No 43 above) request to C Ex to "investigate the RQIA and the Adult protection team (NHSCT) in regards to their handling of reported abuse to patients from	Reply to WB on 20/02/2012 advising that the NHSCT has no powers to investigate RQIA. Agreed to undertake a review of how the Trust had handled these	Proactive action by NHSCT to review the concerns raised by WB.

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
		myself, staff and relatives" in CTH. WB states they have sufficient information to show that vulnerable persons are at risk and authorities are not acting as they should. NHSCT	concerns and nominated a lead person to do so.	
43	13 March 12 Notes of meeting in NHSCT to discuss CTH	NHSCT met to discuss WB's most recent correspondence and the Trust's response to these allegations. BHSCT RQIA NHSCT	Senior manager NHSCT agreed to meet WB to follow up on issues raised.	Evidence of Trust working on WB's concerns.
44	15 March 12 Notes of meeting in NHSCT to discuss WB's allegation of sexual abuse in CTH	Trust staff reviewed actions taken in respect of allegations raised by WB in 2009 dating back to 2007. NHSCT		The review team note that NHSCT was progressing their own internal review.

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
45	20 May 12 Notes of meeting with WB, Patients First Rep and NHSCT	Purpose of meeting was "to satisfy the Trust that correct actions [were] taken in respect of allegations and specifically to identify any learning that could be reinforced for nursing homes, the Trust or others" WB wished investigation into RQIA, Trust noted this was outside their remit. WB requested their view of Trust in respect of care in CTH. Discussed safeguarding of VA in CTH whistleblowing/ Accountability of staff NHSCT RQIA	Trust advised they were undertaking a review and would make further contact with WB once they had completed their work.	Evidence of Trust working collaboratively with WB. The review team has noted that the Trust senior manager "acknowledged that it would have been more helpful if a representative from the Trust" had met with WB directly "at an earlier point".
46	7 June 12 NHSCT file note of meeting to discuss CTH allegations	NHSCT senior staff met to discuss progress in respect of CTH and outcome of discussions with WB. • Noted WB's concerns re moving and handling • Toileting	To progress learning alerts.	Evidence of Trust taking action as a result of WB concerns Review team note the NHSCT record of the meeting which stated: "WB was genuinely motivated around improving practice in

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
		• Personal communication Noted WB had joined a lobby group 'Patients First'.		nursing homes".
47	20 June 12 DHSSPS meeting with WB.	Following contact with the Minister's Private Office on 25/4/2012 WB met with a DHSSPS official and presented photographic evidence and other papers at this meeting DHSSPS	24/9/2012 WB met with the Minister and requested an independent investigation into CTH, RQIA and the NHSCT. WB submitted further evidence. CMO wrote to RQIA 13/9/2013 requesting RQIA to facilitate a review. Review Team established Oct 2013. 7/10/2013 Minister informed WB of a review in regard to concerns made about CTH.	The review team commends the DHSSPS for establishing a review.
48	1 August 12 Letter from RQIA to DHSSPS	Reply from C Ex RQIA to DHSSPS in response to letter regarding WB communication with the DHSSPS. RQIA DHSSPS	DHSSPS advised of action taken by RQIA in respect of contact by WB to RQIA.	

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
49	3 August 12 Meeting of NHSCT and RQIA	NHSCT and RQIA met to share information about complaints raised by WB	Both RQIA and NHSCT agreed to work with the new manager in CTH to improve practice.	Evidence of collaboration between both organisations.
50	30 August 12 Notes of meeting with NHSCT and WB	Follow up of meeting of 20/5/2012 to discuss: • Protection and safeguarding of vulnerable adults within CTH • Accountability of staff • Whistleblowing NHSCT	Action agreed: Learning alert to other care providers and CTH. Trust was satisfied that follow up with NMC and NISCC "was appropriate and assurances have been sought that this has been actioned". This process is outside the remit of the trust.	Evidence of NHSCT staff continuing to work with WB. Evidence that NHSCT wrote to CTH registered provider advising action to report 2 staff members to their regulatory bodies.
51	16 November 12 Telephone call from WB, as a Patients First Representative, to RQIA	WB reported a conversation she overheard in the hairdresser's. A resident had witnessed a domestic clean the toilet and then the table top with the same cloth. The resident reported it to the Matron.	RQIA advised they would inform the inspector and thanked WB for this information.	

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
		The domestic complained to the resident for reporting her.		
52	20 November 12 Notes of meeting in NHSCT with a resident's family and WB	Family of resident requested meeting with NHSCT re manner in which CTH gave notification of decision to ask resident to leave CTH. Other issues discussed included • quality of care • accountability • management issues • regulatory processes	Unsatisfactory outcome for family. They want: • CTH closed down • Staff to be held accountable for failings • Apology from the Proprietor • Trust management to apologise Family advised they would be taking the matter to the Minister. Complaints Chronology (No 50).	The review team met with this family who continue to feel aggrieved that they have not received any apology.
53	22 November 12 Notes of meeting with relatives and NHSCT requested by WB	Meeting with Trust and relatives of deceased resident. Family distressed over end of life care for relative in CTH.	NHSCT agreed to refer the complaint to RQIA and to raise the matter with CTH. RQIA and NHSCT met on 7/02/2013 to discuss the complaint.	Evidence of organisations taking WB's concerns seriously.

No	Date and Source	Issue and Organisations involved	Outcome	Review Team's Findings / Gaps
54	21 Jan 13 Notes of meeting in NHSCT with a resident's family and WB.	Follow up meeting of 22/11/2012 (No 55 above) Dissatisfaction of care of late relative in CTH. Discussion around a number of issues including: • learning from the incident • accountability • referral to regulatory bodies • assurance of inspections and quality monitoring RQIA	NHSCT advised they would liaise with RQIA re assurance of inspections in CTH. Trust to review the assurances within contracting process. Trust to request a further assurance from CTH that they are compliant with standards.	Evidence of Trust taking the concerns of WB and complainants seriously.
55	1 March 13 Telephone call to RQIA from an anonymous staff member in CTH	Reported serious concerns re standard and quality of care provided in CTH. Residents are left to sit for hours at a time without getting appropriate toileting; general standards of care are poor due to staffing levels. RQIA	This whistleblower advised they would be completing a questionnaire for RQIA for their next inspection and was thanked for contacting RQIA.	Issues raised by this whistleblower are the same issues as those raised previously i.e. lack of toileting and residents left sitting for long periods. The review team note that the above recurrent issues were not reported on in RQIA inspection reports over the review period.

4.5 Issues raised by Whistleblowers

An analysis of the summaries of the events associated with whistleblowing in the chronology above shows that the areas of concern were as follows.

Abuse of residents (mentioned at least 16 times) – 9 instances by staff and 7 by other residents

The standard of care provided to residents in Cherry Tree House (mentioned at least 25 times). This included:

- The management of continence (10)
- Moving and handling dependent residents (4)
- Use of bed rails (2)
- The quality of food for residents (1)

Other care concerns included:

- The poor level of hygiene in the Home (mentioned at least 5 times)
- The standard of record keeping and removal of records (mentioned at least 5 times)
- Not implementing procedures for the protection of vulnerable adults (mentioned at least 3 times)
- Medicines management
- Fire safety

Concerns regarding staffing in the home were mentioned at least 18 times. These included:

- Shortages of staff
- Lack of staff training
- Poor communication between management and staff
- Lack of support for whistle blowers

4.6 Organisations approached by whistleblowers

Evidence on whistleblowing was brought to the attention of the review team from a range of sources. These included documents provided by WB, RQIA, Trusts and DHSSPS. In addition, families and others gave evidence at meetings. Some of these concerned issues which WB raised with Cherry Tree House management. As these were not raised with outside organisations when they occurred, they were outside the remit of the review.

Of the 55 events in the chronology above, 39 involved contact with:

- DHSSPS
- The Minister for Health, Social Services and Public Safety
- The Chair of the Northern Ireland Assembly's Health Committee
- The Northern Ireland Human Rights Commission
- The NI Ombudsman for Complaints

- The Northern HSC Trust
- RQIA

4.7 Responses of Organisations

4.7.1 Contact with political representatives

The review team was informed by WB of her contact with Mr Sean Neeson MLA in 2006 and Mr Sammy Wilson MP MLA in 2007. Both these public representatives contacted RQIA to relay her concerns and Mr Wilson also contacted the then Health Minister, Mr McGimpsey. In November 2008 WB contacted Mrs Iris Robinson MP MLA (Chair of Northern Ireland Assembly Health Committee). This led to a meeting on 23 April 2009. WB made allegations of historical abuse dating back to 2007 in Cherry Tree House. In addition, WB provided documentary evidence of poor quality of care and communication issues. (Whistleblowing Chronology No 20). The evidence given to the Chair was passed to Minister McGimpsey.

4.7.2 DHSSPS

On 24 February 2006, WB wrote to the Chief Inspector of Social Services, DHSSPS highlighting the poor standards of care being delivered at Cherry Tree House and about treatment of staff, environmental cleanliness and medicines management issues. She also expressed concern about RQIA's failure to detect these failings during the inspection process. (Whistleblowing Chronology No 2).

Following contact from the DHSSPS, RQIA conducted a complaints inspection on 20 March 2006 (Inspection Chronology No 6) which investigated the issues raised. The report found that "[w]hilst the majority of issues were not substantiated, there were a number of areas where improvement could be made".

On 23 April 2009, the Health Minister received from Mrs Robinson, the Chair of the Health Committee, details of the allegations made by WB concerning poor quality care at Cherry Tree House. The Minister then contacted relevant agencies requesting assurance about the care given in Cherry Tree House. As a result, the Trusts and PSNI instigated Safeguarding Procedures. These investigations concluded that the allegations of historical sexual abuse of residents, by another resident, could not be substantiated.

On 15 May 2012, WB contacted the Health Minister's Private Office and was met by a DHSSPS official on 20 June 2012. (Whistleblowing Chronology No 47). This led to a meeting with the Health Minister on 24 September 2012. The Minister subsequently commissioned this Independent Review of the actions taken in respect of Cherry Tree House which commenced in October 2013.

The review team believe that the DHSSPS acted appropriately when contacted by WB directly and indirectly. On each occasion, the DHSSPS sought assurance, from RQIA and the Trusts, in respect of the care being delivered at Cherry Tree House. The review team commend the DHSSPS for

establishing a review, however we note that in requesting RQIA to facilitate this review, a number of interested parties questioned its independence.

4.7.3 Northern Health and Social Care Trust

The Northern Trust was involved in the investigation of allegations made by whistle blowers, including WB, to other agencies.

WB's first direct contact with the NHSCT was in March 2011 when she requested feedback on issues previously raised with other organisations (Whistleblowing Chronology No 37). WB informed the review team that at that stage she was not aware of the differing roles and responsibilities of the various organisations.

In June 2011, the NHSCT received from RQIA, WB's "Work documents 1, 2, and 3"- detailed statements covering the period from 2009 - 2011.
On 24th November 2011, NHSCT responded to RQIA on the issues contained in the "Work documents". The NHSCT was aware of some issues and these had already been addressed with the Home. The Trust did not propose to take action regarding other historical issues that had been reported by the WB since, given the passage of time, any investigation was likely to be inconclusive.

Meanwhile, on 26 October 2011, WB contacted NHSCT requesting feedback on issues raised in the 'Work Documents'. The Trust replied on 23 November 2011 that, due to confidentiality it could not share information (Whistleblowing Chronology No 40).

In a letter to the Chief Executive NHSCT on 19 January 2012 (Whistleblowing Chronology No 42) WB stated that, due to her frustration, she had contacted the Ombudsman who advised her to write to the Trust for feedback on these issues. The final sentence of these letter states, "I feel that I have lost all confidence in the governing bodies that are meant to protect our vulnerable adults." The NHSCT replied in February 2012 stating: "[i]n terms of the Adult Protection Team I would advise you that it has been agreed to nominate an independent person within the Trust to carry out a review in relation to the concerns you have raised."

Over the period May 2012 to January 2013, WB had several meetings with NHSCT representatives who were conducting the trust's review. At a number of these meetings, WB was accompanied by relatives of residents. The review team note that the Northern Trust record of a meeting held on 7 June 2012 stated that WB was "genuinely motivated around improving practice in nursing homes and to this end is part of a lobby group - Patients First" (Whistleblowing Chronology No.46).

The review team found that the NHSCT acted in accordance with procedures in investigating allegations made by whistleblowers.

The Trust is to be commended for establishing a Review of their actions in relation to complaints about Cherry Tree House and for facilitating meetings with WB and families of concerned residents. However, we believe more

timely and improved communication with WB and families might have increased their confidence in how their concerns were being handled and may even have facilitated resolution of some issues.

4.7.4 Belfast Health and Social Care Trust

The Belfast Trust was involved in 2 whistleblowing events – investigations following allegations made to Chair of Health Committee in 2009 and the allegations made to the Northern Ireland Human Rights Commission in 2010.

The review team found that the Trust acted in accordance with procedures and cooperated with other agencies.

4.7.5 The Regulation and Quality Improvement Authority

RQIA, in carrying out its role as the regulator of health and social care services, was involved with whistleblowing events in the following ways:

- Carrying out investigations into complaints made by whistleblowers (until March 2009);
- From April 2009, forwarding allegations to the Trusts for investigation;
- Responding to enquiries from elected political representatives;
- Providing information to DHSSPS on quality of care provided in the home;
- Cooperating, where appropriate, with other agencies; and
- Meeting and communicating with WB.

Over the period of the review a number of whistleblowers, including WB, contacted RQIA, by telephone or by letter, to express their concerns about care delivered in Cherry Tree House. These allegations were referred to the Trusts or Cherry Tree House for investigation. The review team notes that, at the end of their review period in March 2013, another whistleblower contacted RQIA to raise concerns regarding Cherry Tree House. These were the same issues that had been the subject of complaints and whistleblowing since 2005 - toileting of residents, general standards of care and inadequate staffing levels.

RQIA met with WB on two occasions – in 2006 and 2011 (Whistleblowing Chronology No 3 and No 38). In addition, she made a number of telephone calls to RQIA.

When the review team met with WB she reported that she had felt that the meeting with the RQIA Director of Nursing and Regulation in May 2006 had not been helpful. WB stated that RQIA had suggested to her that she could find employment in another home. No RQIA record of this meeting was available to the review team.

Over the years, WB continued to raise issues with RQIA including reporting bullying and harassment by the management of Cherry Tree House. (Whistleblowing Chronology No 34).

In June 2011, while on suspension from her post in Cherry Tree House, WB met with RQIA after she had provided detailed statements of her concerns

about Cherry Tree House (Work Documents 1, 2, and 3). WB reported to the review team that she attended this meeting alone and felt intimidated. She had difficulty in understanding the different responsibilities of RQIA and the Trust. She said she had not received acknowledgement for bringing these issues to RQIA's attention. The review team was concerned that the RQIA file note of this meeting was brief and did not appear to reflect the seriousness of the issues raised by WB.

There is evidence to show that RQIA was supportive to the WB on some occasions when she contacted them by telephone. However WB told the review team that, when she met RQIA, she did not feel supported and felt that very little was ever done about her concerns as there was little evidence of care practices improving in Cherry Tree House.

4.7.6 Northern Ireland Human Rights Commission

In 2010, the Northern Ireland Human Rights Commission conducted a review of Rights of Older People in Nursing Care. An anonymous respondent to the consultation made allegations of sexual abuse and poor care practices in Cherry Tree House (Whistleblowing Chronology No 28). WB informed the review team that she had raised this complaint.

This information was passed by NIHRC to the NHSCT who initiated Safeguarding procedures in cooperation with the PSNI. The NHSCT advised the NIHRC that the sexual abuse allegations had been investigated previously and were unsubstantiated. Other care issues had been investigated and "there was no evidence to corroborate them". Given that the allegations were made anonymously to the NIHRC it was not possible for it to provide feedback to WB on the outcomes and action taken.

4.8 Meetings with Whistleblowers

In addition to meeting with WB, the review team met with Patients First - an organisation which represents whistleblowers in health and social care. Patients First acted as a conduit with former members of staff of Cherry Tree House, who had previously raised concerns and who subsequently submitted their views to the review team.

It is the view of Patients First that, despite the Health Minister's letter of 22 March 2012, there is often little internal or external support for whistleblowers who wish to raise concerns regarding patient care. They expressed concern at the DHSSPS's level of commitment to implement a robust policy in relation to protection for whistleblowers. We understand that this group has identified a number of ways to enhance the current whistleblowing strategy and is willing to collaborate with the HSC to achieve this.

The review team was told that whistleblowers believe that they are often the "scapegoats" and on occasions employers find reasons to dismiss them. They suggested that organisations that fail to address the concerns of whistle blowers are those with weak leadership. It was their view that such leaders are rarely held to account for failures within their organisations.

4.9 Whistleblowing in other jurisdictions

The review team note that there is a number of whistleblowing initiatives being developed throughout the U.K. Examples include:

- NHS Scotland has had a confidential phone line in place since April 2013 for staff who want to raise concerns; and
- Protocol between Her Majesty's Chief Inspector of Prisons[8], Independent Monitoring Boards and Prisons and Probation Ombudsman for England and Wales to assist joint working in respect of concerns raised by prisoners or those acting on their behalf.

4.10 Comments and Recommendations

The review team is of the opinion that WB both consistently and persistently pursued her issues of concern. It appears that she was frustrated in her attempts to resolve issues of concern locally and she escalated her concerns to other agencies.

From the evidence available to the review team, it is clear that significant time and resources were spent by external agencies trying to investigate allegations made by WB. This included holding a number of Safeguarding meetings, on occasions with 15 staff attending from 4 different organisations. WB would not have been aware of this activity and, because of the confidential nature of many of the matters investigated, would not have received feedback. We recognise that this must have contributed to her continued frustration and lack of confidence in the authorities. Without compromising the protection of data and respect of confidentiality, reassurance that her disclosures were being heard may have alleviated WB's concerns to some extent.

The review team also acknowledges the potential for whistleblowers to become isolated within the workplace and has noted WB's feelings of being bullied.

We recognise that statutory organisations have difficulties in investigating allegations of historical abuse and poor care practice because residents may have died or staff moved on. However, the review team believes that if, after being investigated, complaints had been followed through, and if contemporaneous records in Cherry Tree House had been inspected, some of these matters could have been addressed at the time they occurred. The management of continence was a recurring issue raised by WB over many years and the review team notes that on 1st March 2013, a new whistleblower made allegations about issues, including continence management, general standards of care and inadequate staffing levels. The review team note that these had been matters of concern for WB and others over the period of the review.

[8] http://www.justice.gov.uk/downloads/about/hmipris/hmip-imb-ppo-protocol.pdf

Recommendations

Following consideration of the written evidence and the views of families, and others including whistleblowers, the review team makes the following recommendations.

8 Government departments should give consideration to the review of the Public Interest Disclosure (Northern Ireland) Order 1998 in light of the recommendations of the Whistleblowing Commission's report of November 2013. Of particular relevance are the following:

- The licence or registration of organisations which fail to have in place effective whistleblowing arrangements should be reviewed. (Recommendation 3)

- Regulators have a clear procedure for dealing with whistle blowers who come to them, including the provision of feedback, and explaining when it is not possible or reasonable to do so. (Recommendation 4)

- Regulators include whistleblowing in their annual reporting mechanisms, including in accountability hearings before Parliament. (Recommendation 5)

9 The Minister should seek assurance that all HSC organisations have robust whistleblowing policies and procedures which reflect the spirit of his letter of 22 March 2012.

10 The DHSSPS should consider implementing best practice in other jurisdictions in relation to the protection of whistleblowers.

11 Each HSC organisation should consider nominating a non-executive director as champion for whistleblowing issues.

12 RQIA should assure itself that, in line with existing Minimum Care Standards, all residential and nursing homes have in place a whistleblowing policy that includes support and protection for whistleblowers.

13 RQIA should assure itself regularly that it complies with its Guidance for Whistleblowers (October 2013).

14 Updated training on whistleblowing should be provided following any change in legislation or policy. This should promote both a culture and environment which encourage staff to feel able to raise concerns about health and social care matters. Such training should be mandatory for all staff and be an integral part of a regional awareness campaign.

5.0 RQIA Inspections of Cherry Tree House

5.1 Introduction

During the period of the review, there have been organisational and legislative changes which have impacted on the inspection of nursing and residential homes. RQIA has provided a paper outlining these changes (Appendix 2). This includes a description of an Inspection Planning Approach support by an Inspection Planning Tool (IPT). This enables it to assess the relative levels of risk and focus its attention on homes failing to provide good quality care.

Inspections carried out by the RQIA may be announced or unannounced.
It is the policy of the RQIA that all inspections are undertaken in a manner that promotes a culture of best practice and encourages continuous improvement.

The purpose of inspection is to consider whether the service provided to patients was in accordance with their assessed needs and preferences and was in compliance with legislative requirements, minimum standards and other good practice indicators. This is achieved through a process of analysis and evaluation of available evidence.

RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the Minimum Standards.

The inspection process has three key parts; self-assessment (including completion of self-declaration), pre-inspection analysis and the inspection visit by the inspector.
Specific methods/processes used in this inspection include the following:

- Analysis of pre-inspection information
- Discussion with the registered manager
- Examination of records
- Consultation with stakeholders
- File audit
- Tour of the premises
- Evaluation and feedback

Any other information received by RQIA about this Registered Provider would also be considered by the Inspector in preparing for inspection.

The following table shows the number and type of inspections carried out by RQIA in the period examined.

Year	Care	Medicines Management	Estates	Total
Jan/March2005	1			1
2005/06	1	1		2
2006/07	5	1		6
2007/08	5	6	1	12
2008/09	1			1
2009/10	3	2	1	6
2010/11	3	1	1	5
2011/12	4	1*		5
2012/13	4	1		5
Totals	27	13	3	43
* Medicine Information Return				

Over this period of 8 years and 3 months, Cherry Tree House had 43 inspections, an average of 5.2 inspections each year. The fact that Cherry Tree House had so many inspections demonstrates that RQIA appreciated that a high level of monitoring was required to try to ensure that care was being provided to an acceptable standard.

The chronology that follows briefly outlines the date, type and findings of each of these 43 inspections. It starts with an unannounced inspection on 7 February 2005 and ends with an unannounced medicines management inspection on 14 March 2013. The findings of the review team are noted in the final column.

5.2 Inspection Chronology

	Date	Inspection	Review Team Findings / Gaps
1	7 February 05	Unannounced Care Inspection The focus of the inspection was on "administration of medicines". This inspection reviewed the three recommendations made at the previous announced inspection on 12/08/2004 and found that all three issues had been addressed. This inspection resulted in no requirements or recommendations in respect of the administration of medicines but made one requirement and five recommendations in respect of other matters, including the use of bed rails. The inspector spoke to twelve residents, one relative and seven members of staff. Comments made about the home were positive and no issues or concerns were raised.	This inspection was conducted by the NHSSB Registration and Inspection Unit. It may have been in response to the Home's investigation of the disappearance of drugs – reported to R&I Unit on 24/01/2005 January. However the inspection report makes no reference to this. The report does not refer to the Pharmaceutical Inspection which had taken place on 30/07/2004 which made eight requirements and recommendations (not differentiated) in respect of the administration of medicines.
2	13 June 05	Pharmaceutical Inspection This inspection reviewed the eight requirements and recommendations made in the previous inspection (30/07/2004) and found that only three had been fully addressed. This inspection made three requirements and four recommendations.	This was the first inspection carried out in CTH by RQIA. The requirements and recommendations of this inspection report cover matters that recur in several further inspections over the period reviewed – in particular the standard of recording of: • incoming medicines • the administration of medicines • outgoing medicines

	Date	Inspection	Review Team Findings / Gaps
3	6 September 05	<u>Announced Care Inspection</u> The focus of this inspection was on the implications for the home of changes to regulation legislation and the impact of new standards of the provision of care. It was found that the one requirement and five recommendations made as a result of the previous inspection on 7/02/2005 had all been "addressed as agreed". It was reported that the home was clean and welcoming. However, as a result of this inspection, three recommendations were made, including the need for the refurbishment of communal areas. The inspectors met informally with five residents, two relatives and three members of staff. Comments made about the home were positive and no issues or concerns were raised.	Over the period reviewed, a number of inspection reports highlighted the need for refurbishment and redecoration of the home.
4	4 January 06	<u>Complaint Inspection</u> This inspection followed a complaint regarding the care a relative was receiving at CTH. This inspection resulted in one requirement and two recommendations being made. One of the recommendations regarded the Home's management of complaints.	RQIA responded to this complaint in a timely fashion. The review team noted that subsequent care inspection reports did not refer to this complaint inspection. Over the period reviewed, inspection reports identified inconsistencies in the management of complaints.

	Date	Inspection	Review Team Findings / Gaps
5	15 February 06	Complaint Inspection The inspection followed a further complaint by same relative as No 4 above. As a result of this inspection, three requirements, including the production of an action plan for staff training, and one recommendation were made.	The review team noted that RQIA responded to this complaint in a timely fashion. CTH produced the action plan for staff training as required and issued were addressed
6	20 March 06	Complaint Inspection This inspection was held to investigate a number of issues that had been raised by an anonymous complainant in a letter to DHSSPS. "While the majority of issues raised could not be substantiated, there were a number of areas where improvement could be made." Three "improvements" in respect of the issues investigated and three improvements in respect of other issues were made. The inspector spoke with 6 residents, 3 relatives and 4 staff members. All comments about the home were positive and no issues or concerns were raised.	It subsequently transpired that the anonymous complainant was WB Whistleblowing Chronology (No 2). RQIA responded to this complaint in a timely fashion and issues were addressed.
7	30 April 06	Unannounced Care Inspection The focus of this inspection was on "the Sunday morning routine". The inspector spoke to eight residents, one relative and eight members of staff. One staff member raised issues about communication following a period of	The inspection report did not make reference to three complaints inspections (Nos 4, 5 and 6 above) that had taken place recently, nor to the three outstanding requirements, the three recommendations and the six "improvements" contained in those reports.

	Date	Inspection	Review Team Findings / Gaps
		absence from CTH, and redecoration within the home. These were noted by the inspector and were reflected in the recommendations. This inspection reviewed the three recommendations made as a result of the inspection of 6/09/2005 and found that one (in respect of the refurbishment of communal areas) had not been fully addressed. This inspection identified two requirements (one of which was in respect of the need for a refurbishment programme) and six recommendations.	
8	1 August 06	<u>Announced Pharmaceutical Inspection</u> This inspection reviewed the three requirements and four recommendations made following the previous inspection on 13/06/2005. It identified that only one requirement and one recommendation had been addressed in a satisfactory manner. The inspection resulted in seven requirements and four recommendations being made. One requirement was to carry out an investigation into the management of schedule 2 controlled drugs within two weeks. On 24/08/2006 CTH provided a report on the management of schedule 2 controlled drugs and a check list which indicated that all the requirements and recommendations made following the inspection were being addressed.	It is noted that, in a letter to CTH on 15/08/2006, the Pharmacist expressed their concern that a number of requirements made in June 2005 had not been addressed. The review team commends this action. The review team notes that despite CTH's assurances the Pharmacy Inspection on 18/01/2007 Inspection Chronology (No11) found that only a limited number of requirements had actually been actioned by CTH.

	Date	Inspection	Review Team Findings / Gaps
9	14 November 06	<u>Announced Care Inspection</u> "The intended focus of this inspection was to review service user involvement and management of complaints. However, this was given a cursory view due to other matters arising" (page 3). The inspector spoke to five residents, one relative and several staff members. All comments about the home were positive and no issues or concerns were raised. The two requirements and six recommendations made following the inspection of 30/04/2006 were found to have been addressed. The inspector spoke to five residents, two relatives and six staff. One resident raised an issue re activities the inspector reflected this in the report. Three members of staff expressed dissatisfaction at staffing levels, especially over a recent weekend. Thirteen requirements were made. These included: • The need to address staffing shortfalls • The need for clinical supervision of staff • The need for a range of staff training • The use of bed rails • The need for activities for residents Six recommendations were made, including the need for an audit of accidents to be carried out and further redecoration of CTH. The new manager for CTH submitted an action plan on 23/11/2006. This was found to be "comprehensive" and CTH was asked to submit "a monthly action plan to include the dates on which each requirement was achieved".	The review team note that the inspector responded to issues of concern which became evident on the day of inspection. This inspection, highlights a number of issues in the period reviewed that frequently recur: • Staffing levels • Clinical supervision • Staff training • Activities for residents • Use of bed rails The review team was not provided with evidence that CTH provided RQIA with the monthly action plans

	Date	Inspection	Review Team Findings / Gaps
10	11 January 07	<u>Announced Care Inspection</u> The focus of the inspection was to follow up on the issues raised in the inspection of 14/11/2006. "Good progress" had taken place to address these. Seven of the thirteen requirements and four of the six recommendations made in November 2006 were reported to "have been addressed" (para 3). As a result of this inspection nine requirements (covering thirteen issues) were made. Six of the issues were restated from the previous Quality Improvement Plan (QIP). These included: • Staff training • Clinical supervision • Activities for residents • Redecoration Three recommendations were also made – one of these in respect of registering care staff with NISCC, was restated from the previous QIP.	The inspection report provided limited assurance in respect of the previous requirements and recommendations that were stated to have been addressed as no supporting evidence was recorded.
11	18 January 07	<u>Unannounced Follow-up Pharmaceutical Inspection</u> The purpose of the inspection was to follow-up on the inspection of 1/08/2006. Despite the checklist provided by the home on 24/08/2006, this inspection found that only "a small number of these had been addressed, and the remainder had yet to be actioned… the manager agreed that significant improvements were required in the management of medicines" (para 6). Six requirements made as a result of this inspection.	The review team note that, despite the CTH's assurance on 24/08/2006 that action had been taken on the requirements and recommendations, there was no evidence these improvements had been sustained by CTH.

	Date	Inspection	Review Team Findings / Gaps
12	21 February 07	<u>Unannounced Follow-up Pharmaceutical Inspection</u> The purpose of the inspection was to determine what progress had been made since the previous inspection on 18/01/2007. Of the six requirements made in the previous inspection, five had been addressed and one required further attention. "An improvement in the management of medicines was evidenced during this visit, however ongoing improvement is necessary" (para 6). This inspection resulted in two requirements being made. The CTH response, dated 8/03/2007, indicated that both matters had been addressed.	The inspector had also visited CTH on 1/02/2007 to investigate the theft of schedule 2 controlled drugs and Folic Acid tablets which had been notified to RQIA on 26/01/07 and was investigated. The incident is not explicitly referred to in this inspection report. The review team note that the Pharmacy inspector visited the Home on three occasions in early 2007 and there was a reported improvement in CTH's handling of medicines.
13	16 March 07	<u>Unannounced Care Inspection</u> Joint Care and Pharmacy inspection (No14, below). The focus of the inspection was on staffing levels and the requirements made following the inspection on 11/01/2007. It was noted that five staff had ceased to be employed at the home since the previous inspection. The consequent shortfall was being covered by permanent staff working additional hours and by the use of agency staff. The report stated "[e]very effort must be made to ensure that suitable permanent staff are appointed as soon as possible" (para 6.2). The inspection found that, of the nine requirements made of the previous inspection, six had been fully achieved and three partially achieved. Two of the three recommendations had been achieved.	

	Date	Inspection	Review Team Findings / Gaps
		Five requirements were made, including: • The need to fill vacant posts • Induction of agency staff • Staff training • Clinical supervision Four recommendations were made, including: • The need for an Activity Therapist to be appointed • Audit of accidents and incidents The inspector spoke to five residents, three relatives and four members of staff. All comments about the home were positive and no issues or concerns were raised.	Several of the requirements and recommendations were being made for the second or third time since 2005.
14	16 March 07	<u>Unannounced Follow-up Pharmacy Inspection</u> This inspection took place alongside the care inspection (see No 13, above). This inspection found that the two requirements made following the inspection on 21/02/2007 had been addressed. However further attention was necessary on the maintenance of the Medicine Administration Record. As a result of this inspection, 3 requirements were made.	

	Date	Inspection	Review Team Findings / Gaps
15	6 April 07	<u>Unannounced Complaint Investigation</u> On 5/04/2007, RQIA had received an anonymous written complaint which raised concerns about: • Dependent, critically-ill patients at risk of falls, neglect, malnutrition, abuse etc. • Staff management issues • Staffing levels following the resignation of 4 staff • Attitude of manager and deputy manager to staff and relatives. The inspector spoke to 6 residents and two relatives and 11 staff members. Staff raised issues in regard to the complaint and the inspector made a number of requirements re staffing concerns. The inspector found that the only aspect of the complaint that could be upheld was that in respect of staffing levels, having found that some staff were working excessive hours (in one instance, 74 ¾ hours in a week) and that there were staff shortages on several dates. This inspection resulted in 5 requirements being made. Three were in respect of staffing issues and one was regarding the need for food and fluid balance charts. On 13/04/2007, RQIA wrote to the NHSC Trust to advise them that, following this inspection, RQIA was concerned about staffing issues and advised that the Trust should “cease to admit any further patients/residents until there is evidence of stability in terms of staffing”.	Complaints Chronology (No 22). Whistleblowing Chronology (No 6). RQIA is commended for taking this action.

	Date	Inspection	Review Team Findings / Gaps
16	18 April 07	Unannounced Follow-Up Pharmaceutical Inspection The purpose of the inspection was to determine the progress made in addressing the requirements made following the inspection of 16/03/2007 (see No13, above). The inspection found that only one of the three requirements made at the previous inspection had been addressed. The report stated "sustained improvements in the maintenance of personal medication records and medicine administration records are required." (para 6) This inspection made seven requirements. RQIA received the QIP from CTH on 17/05/2007. It indicated that six of the seven requirements had been addressed and one partially addressed.	For 5 of the 7 requirements, CTH gives no details of the action taken to address the issues. There is no evidence of this being challenged by RQIA.
17	24 April 07	Unannounced Care Inspection The focus of this inspection was to monitor staffing provision and progress in respect of requirements and recommendations made following the previous two inspections. The inspection report indicated that of the five requirements made following the inspection of	This inspection took place in the context of the suggested suspension of admissions to CTH because of staffing difficulties. (see No 15 above) The day after this inspection, RQIA wrote to the NHSCT to suggest that the suspension of admissions be lifted. The inspection report does not refer to the requirements made following the complaint

	Date	Inspection	Review Team Findings / Gaps
		16/03/2007, three had been achieved, one partially achieved and one not achieved. Of the four recommendations, one had been achieved and three partially achieved. The inspectors reported that additional permanent staff had been and were being recruited. The manager of the Home was asked to "continue to submit weekly duty rotas to the Authority until further notice" (para 7.1). The inspection resulted in two requirements (covering six issues) being made. These included: • Clinical supervision • Staff training • Use of bed rails • Records of food intake • Recording of complaints Four recommendations, including the employment of an activity therapist, were made. The inspector spoke to many residents and with catering and care staff members. All comments about the home were positive and no issues or concerns were raised.	investigation on 6/04/2007. However, it is clear that the inspectors addressed the issues. The inspection report provides detailed assurance that the requirements and recommendations made in March 2007 had been implemented. The review team was not provided with evidence that CTH provided weekly duty rotas. This is the fourth time since 2005 that • staff training • clinical supervision • residents activities / employment of an activity therapist have been mentioned in QIPs.

	Date	Inspection	Review Team Findings / Gaps
18	27 July 07	<u>Unannounced Medicines Inspection</u> The inspection found that of the seven requirements made following the inspection of 18/04/2007, six had not been adequately addressed. The report stated: "Standards in record keeping, administration of medicines and medicine storage and stock control require urgent attention". On 31/07/2007 RQIA issued CTH with 2 Notices of Failure to Comply with Regulations in respect of medicines management. On 13/09/2007 a further inspection confirmed compliance with legal requirements in respect of the Failure to Comply Notices.	It appears that the improvement in the administration of medicines, noted in March 2007 (see No 12, above) was not sustained. RQIA should be commended for taking prompt enforcement action. This is the first inspection report which contains lists of actions the inspector may have undertaken, headed by the words "Evidenced by all or some of the following". This inspection format offers limited assurance as it is not clear what evidence the Inspector actually used to reach these conclusions.
19	8 August 07	<u>Announced Care Inspection</u> This inspection found that, of the six issues in the two requirements made following the inspection of 24/04/2007, three had been addressed, two had been partially addressed and one had not been addressed. The report implies that none of the three recommendations had been addressed. This inspection made five requirements, covering	

	Date	Inspection	Review Team Findings / Gaps
		thirteen issues. These included: • Updating CTH complaints policy • Staff training • Clinical supervision • Redecoration Seven recommendations, covering ten issues, were also made. These included: • Audit of accidents • The need for formal staff meetings The inspectors spoke to eight residents, two relatives and "the majority of staff". Resident's comments about the home were positive and no issues or concerns were raised. One relative raised areas of dissatisfaction which were addressed and improvements made.	This is the fifth time since 2005 that staff training and clinical supervision are mentioned in QIPs.
20	27 November 07	<u>Estates Inspection</u> This inspection resulted in 28 requirements: • 13 general maintenance • 7 fire safety • 8 health and safety. The inspector noted that many fire doors throughout the Home were wedged open, compromising fire safety.	There is no evidence that RQIA sought assurance that these requirements were being addressed by CTH. They are not mentioned in the next Estates Inspection; 14 months later, in January 2009 (see No 24, below).

	Date	Inspection	Review Team Findings / Gaps
21	13 December 07	<u>Unannounced follow-up Medicines Inspection</u> The inspection "was undertaken to examine the current arrangements for the management of medicines within the home, and to examine the steps being taken to improve the standards in place for the management of medicines following a number of medicines inspections over the last year" (page 2). Each of the 4 requirements made following the inspection on 27/07/2007 was found largely to have been addressed. The 2 recommendations had been addressed. The inspection noted improvements in recording and administration of medicines, but added "robust procedures and a consistent approach are necessary in order to achieve the required standard at all times" (para 4). This inspection resulted in 4 requirements and 2 recommendations being made.	The review team note that Pharmacy Inspectors visited the home on 8 occasions in 2007. • 6 inspections • 1 investigation • 1 follow up to failure to comply notice
22	21 August 08	<u>Unannounced Care Inspection</u>	This is the only inspection of CTH in the inspection year 2008-2009. There had been 12 inspections in 2007-2008. This inspection report does not refer to issues which had arisen since the previous inspection: • Tissue viability and nutritional assessments, raised in January (Complaints Chronology No 25) • The series of falls in the Home in April and

	Date	Inspection	Review Team Findings / Gaps
			May (Complaints Chronology No 26 to 28) • Case of C Difficile in July 2008 (Complaints/ Chronology No 29) The inspection report does not provide evidence that the issues raised in respect of a complaint of a relative to the NHSCT on 28 July 2008 (Complaints/ Chronology No 30) – weight loss, lack of heat, lack of medical attention – were addressed during the inspection. An RQIA file note on 18 August states the issues in respect of this complaint will be looked at during the next inspection.
		The inspection reviewed the 5 requirements and 7 recommendations made following the previous inspection on 8/08/2007. Four of the requirements and all 7of the recommendations were recorded as having been addressed.	In 9 instances, the assurance was recorded as "The Registered Manager confirmed that this action was taken", or similar wording. In respect of staff meetings the report adds "minutes and records of staff attendance were not examined during this inspection" This provides little assurance that the requirements and recommendations had been addressed.
		This inspection resulted in 10 requirements, covering 28 issues, being made. These included: Recording of complaints ("restated") Staffing levels Staff training in COSHH ("restated") Staff supervision ("restated")	This is the sixth time since 2005 that staff supervision and training in COSHH have been mentioned and the third time since 2005 for CTH's complaints procedure.

	Date	Inspection	Review Team Findings / Gaps
		Three recommendations were also made, including the need to recruit a Deputy Manager. The inspector spoke to thirteen residents and four members of staff. All comments about the home were positive and no issues or concerns were raised.	
23	8 January 09	<u>Announced Care Inspection</u> This inspection reviewed the 10 requirements and 3 recommendations made following the inspection on 21/08/2008. Six requirements had been fully addressed, 3 partially addressed and one (in respect of clinical supervision) was not addressed. The three recommendations had been addressed. This inspection resulted in 7 requirements, covering 21 issues, being made. These included: • Complaints ("restated") • Care records ("restated") • Staff recruitment • Staff training ("restated") • Staff supervision ("restated for the second time") • Staffing levels • Checking NMC status of nurses There were also 7 recommendations, covering 15 issues. These included: • The recruitment of a Deputy Manager	This is the first report which lists the Minimum Care Standards being inspected (in this instance, six standards) and the evidence used by the Inspector to assess the Home's practice. There is no evidence that this inspection addressed the issues raised by WB on 16/10/2008 Whistleblowing Chronology (No 8). As with the previous inspection, the assurance recorded for several issues is a statement such as "the registered manager informed the inspector that this requirement had been met". This provides little assurance that the requirements and recommendations had been addressed. This is the seventh time that staff supervision and staff training have been mentioned and the fourth time for complaints policy. This is the fifth time the need for an Activity Therapist had been mentioned. since March 2007.

	Date	Inspection	Review Team Findings / Gaps
		• The recruitment of an Activity Therapist • Updating the Home's Vulnerable Adults policy The inspector spoke to 13 residents, 7 staff and 3 relatives and in addition received two completed questionnaires. In general comments about the home were positive. Two relatives raised concern over lack of activities for residents. This was reflected in the recommendations. On 26 January, RQIA contacted the registered provider of CTH to emphasise that a number of staffing issues needed to be addressed: • Deputy Manger • Sufficient registered nurses on the am shift • Activity therapy.	This is the first inspection report that details the number of pre-inspection questionnaires sent to residents, relatives and visiting professionals and the number returned. The returned questionnaires were not available for the review team to consider. The report notes that specific issues raised by one visiting professional were discussed with the manager. However, the report does not record the nature of these issues.
24	19 January 09	<u>Estates Inspection</u> This inspection resulted in 11 requirements being made: • 5 general maintenance • 2 fire safety • 4 health and safety.	The report of this inspection does not refer to the 28 requirements made following the previous inspection on 27/11/2007 (see No 20). However, 3 of the general maintenance requirements, 1 fire safety requirement and 1 health and safety requirement are similar to these made as a result of the previous inspection.

	Date	Inspection	Review Team Findings / Gaps
25	26 January 09	<u>Unannounced Medicines Inspection</u> The inspection addressed the 4 requirements and 2 recommendations made following the previous inspection on 13/12/2007. It was found that 1 requirement had been addressed, 2 partially addressed and 1 not addressed. One recommendation had been implemented and the other had been partially implemented. This inspection resulted in 5 requirements and 5 recommendations being made.	This inspection took place 4 days after CTH had reported to RQIA that a resident had been without prescribed medication for 8 days. While this incident is not cited as the reason for the inspection, it is referred to in the inspection report and one of the requirements addresses the issue.
26	14 May 09	<u>Unannounced Care Inspection</u> "The main focus of the inspection was to examine infection prevention and control practices and procedures…an additional focus of the inspection was…the morning routine" (para 7). The inspector spoke with nine residents and six staff. All comments about the home were positive and no issues or concerns were raised. The inspection reviewed the requirements following the previous inspection on 8/01/2009. Of the 7 requirements, 3 had been addressed, 2 partially addressed and 2 not addressed. Of the 7 recommendations one had been addressed,	This inspection took place a few weeks after allegations of historical sexual abuse and poor standards of care were made to the Chair of the Health, Social Services and Public Safety Committee in the Northern Ireland Assembly. A letter from RQIA to the Social Services Inspectorate, DHSSPS, dated 6 May states "the inspector will ensure that the care issues identified in the correspondence will be examined during the inspection". However, the report of the inspection makes no reference to these matters. For example, WB had stated that there were reports in the CTH communication book regarding the toileting of residents. There is no evidence that the inspector checked the communication book.

	Date	Inspection	Review Team Findings / Gaps
		2 partially addressed and 4 not addressed. This inspection resulted in 14 requirements, covering 67 issues. These included: • Infection prevention and control (56 issues) • Staff training (stated for 2nd time) • Staff supervision (stated for 4th time) • Activity therapist • Use of bed rails 10 recommendations, covering 18 issues, were also made. These included: • Infection prevention and control • Complaints management • Staff training (stated for 2nd time) • Staff supervision (stated for 2nd time) • Need for a deputy manager(stated for 2nd time) • Staff meeting and minutes available to staff (stated for 2nd time) • Vulnerable Adults policy (stated for 2nd time) Following this inspection, meetings were held with the proprietor of the Home at which RQIA expressed its concerns in respect of: • Infection control • Care planning • Policy development • Staff supervision • Complaints management	The report of this inspection was sent to CTH on 29/10/2008, i.e. 5 months later. In a number of instances the registered manager's assurance (referred to in Nos 21 and 22, above) regarding the requirement is followed by the statement: "This was not reviewed by the inspector during this inspection". Of particular concern was that the inspector did not assure herself that a robust system was in place for checking the registration of nurses with the NMC. (See No 39, below). This inspection was a thorough (and concerning) assessment of CTH infection prevention and control practices. This is the eighth time since 2005 that staff supervision and staff training have been mentioned, the fifth time for complaints policy.

	Date	Inspection	Review Team Findings / Gaps
		• Activity programme • Deputy Manager The Proprietor was told that RQIA was considering taking enforcement action and the Home was given eight weeks to demonstrate improvements.	
27	6 August 09	<u>Unannounced Care Inspection</u> The inspection was carried out to review progress in respect of the requirements made following the previous inspection on 14/05/2009. Of the 14 requirements, 7 had been addressed, 5 partially addressed and 2 not addressed. Of the 10 recommendations, 4 had been addressed, 2 partially addressed and 4 not addressed. The inspectors noted some improvements but recorded that "it was disappointing to note the lack of progress in relation to complaints investigation, activity provision and policy development" (para 7). This inspection resulted in 16 requirements, covering 31 issues. These included: • Infection control (22 issues) • Complaints management (stated for 2nd time) • Activities (stated for 2nd time) • Fire doors The QIP stated that a total of 15 requirements were being made for the second time and one for the third	There were concerns recorded in CTH communication book in April and May 2009 in respect of toileting, bed rail and fire safety issues. Whistleblowing Chronology (No 22). There is no evidence to give assurance that records were reviewed and that these matters were looked at during this inspection. However, the report gives good assurance of the assessment of the previous requirements and recommendations, with statements such as "observations made during the inspection confirmed that the above aspects of the requirement had been met". This is the sixth time since 2005 that deficiencies in CTH complaints policy have been mentioned Many of these Requirements and Recommendations related to matters which RQIA

	Date	Inspection	Review Team Findings / Gaps
		time. Seven recommendations, covering 9 issues were also made. These included: • Infection control (stated for 2nd time) • Complaints procedure (stated for 2nd time) • Staff training (stated for 3rd time) • Vulnerable Adults policy (stated for 3rd time) • Appointment of Deputy Manager(stated for 3rd time) The inspector spoke with five staff no issues or concerns were raised and recorded no concerns regarding observation of residents.	had discussed with the proprietor following the previous inspection (see No 26 above) and, about which the evidence indicated that CTH had taken little or no action in the interim. In view of this the review team would have expected enforcement action following this inspection.
28	30 September 09	<u>Unannounced Medicines Inspection</u> This inspection reviewed the 5 requirements and 5 recommendations made following the previous inspection on 26/01/2009. Three requirements had been addressed, 1 partially addressed and 1 not addressed. All 5 recommendations had been addressed. This inspection resulted in 6 requirements (covering 8 issues) being made. The inspector commented; "These should be read in the context of a Home where steps are being taken to address the issues with evidence of progress and improvements throughout the Home" (para. 7). The Home's QIP, with actions taken, was returned to RQIA and noted by the inspector on 2/11/2009.	

	Date	Inspection	Review Team Findings / Gaps
29	5 & 6 January 10	<u>Announced Care Inspection</u> This was an inspection over 2 days and examined 5 standards of care and found that the home had a maturity rating of "developing" on all five. There was a detailed report of the issues raised on the previous inspection on 6/08/2009. Fourteen of the 16 requirements were found to be fully met. Two requirements (in respect of infection prevention and control and care records) had been partially met. Six of the 7 recommendations had been fully met. One recommendation (in respect of the decor in some bedrooms) had not been met. It was noted that a Deputy Manager and an Activities Therapist had been appointed. This inspection led to 6 requirements (covering 9 issues). These included: • care records and • infection control issues. The 5 recommendations made included the need for staff meetings. The inspector received six completed questionnaires, spoke to 10 residents individually and others in a group setting. Five relatives completed questionnaires and 2 relatives spoke with the inspector. Ten staff members spoke with the inspector and five returned completed	This was the first inspection report that assessed CTH levels of achievement and position on a maturity matrix for each standard examined at the inspection. CTH own assessment of its practice was complemented by the Inspector's assessment. Most of the assurance was provided by the observations of the Inspector. This demonstrates improved assurance.

	Date	Inspection	Review Team Findings / Gaps
		questionnaires. Six visiting professionals returned completed questionnaires. All comments about the home were positive and no issues or concerns were raised.	
30	11 May 10	<u>Unannounced Care Inspection</u> On the morning of this inspection, an anonymous call from a member of staff to RQIA raised concerns about staffing levels, administration of medicines, residents serving their own tea and allegations of abuse. They further alleged that references to these matters had been ripped out of the communication book. "It was evident that there is discontent among staff which is impacting on the delivery of care". (Page 6). The inspector examined staff rotas and found shortfalls as a result of staff absence. The inspector referred to recent anonymous telephone calls and letters to RQIA and other organisations about CTH. She also became aware of two incidents which she asked the manager to investigate and provide RQIA with her reports. The inspection reviewed the 6 requirements and 5 recommendations made following the inspection held on 5 & 6/01/2010 and found that all had been fully met.	While there was evidence in the inspection report that a number of issues which had arisen from complaints and anonymous calls, were addressed during this inspection, there was no evidence that previous complaints in respect of: • incontinent residents (residents being left soiled all day), • the recording of fluid and food intake • failure to routinely hoist residents • residents strapped into chairs for lengthy periods allegations of abuse were addressed. Complaints Chronology (No 44 and 45). There was evidence that fire safety concerns had been inspected during this visit. Complaints Chronology (No 46). There is no evidence that the communication book was inspected, despite the allegation that pages had been ripped out

	Date	Inspection	Review Team Findings / Gaps
		The inspection examined the standard of care in respect of the programme of activities and events and assessed the home's maturity level as "practising". The inspection made 6 requirements, including one about staffing levels, and 1 recommendation. The inspector spoke to 6 residents who raised no issues or concerns. The seven staff members raised a range of issues and a number were reflected in the requirements and recommendations.	Good assurance was provided by the Inspector's observations.
31	20 August 10	<u>Announced Estates Inspection</u> This inspection found that since the previous inspection in January 2009 "significant time and effort has been invested in the home… to improve the quality of the built environment" (para 2.1). Five requirements were made – 2 general maintenance, 2 fire safety and 1 health and safety	The report of this inspection does not refer to the 11 requirements made following the previous inspection on 19/01/2009 (see No 24, above). Neither does it refer to the incident when a resident left CTH through an unalarmed fire door in April 2010. Complaint Chronology (No 46).
32	25 & 26 October 10	<u>Announced Care Inspection</u> The inspector examined staff rotas for a four week period and found shortfalls. Pre-inspection questionnaires returned by 6 relatives and 5 staff members indicated concern that the level of staffing was not sufficient to meet the needs of residents. "The majority of staff spoken with indicated that they felt that staffing levels were insufficient" (para 7.1).	This inspection took place 12 days after RQIA received an anonymous letter making a number of allegations regarding care in the Home. There is evidence that many of the issues raised in the letter were examined during this inspection. Whistleblowing Chronology (No 30).

	Date	Inspection	Review Team Findings / Gaps
		This inspection reviewed the 6 requirements made following the inspection and found that 5 had been fully met and 1 partially met. The 1 recommendation had not been met. The inspection examined 4 standards of care. The assessed maturity levels were "practising" for 2 standards and "developing" for 2 standards. The inspection resulted in 10 requirements, covering 20 issues. These included: • Staffing levels • Issues concerning residents' meals • Management of complaints • Fluid intake management 8 recommendations were made, including • Competency documentation for nurses in charge of the home • The need for a monthly accident audit When the QIP was returned by CTH, the inspector found it deficient in several places. CTH was asked to resubmit the QIP and did so, on 15/03/2011.	The review team notes that: "Due to unforeseen circumstances", the report of this inspection was not sent to CTH until 22/12/2010. The review team note the challenge by RQIA in respect of the poor quality of the QIP provided by CTH.

	Date	Inspection	Review Team Findings / Gaps
33	25 October 10	<u>Unannounced Medicines Management Inspection</u> This inspection coincided with the first day of the inspection reported (see No 32 above). The inspection found that 5 of the 6 requirements made following the previous inspection on 30/09/2009 had been addressed. One had been partially addressed. The inspector reported that "arrangements for the management of medicines in this home are of a satisfactory standard" (para 7). As a result of this inspection, 3 requirements and 1 recommendation were made.	
34	20 April 11	<u>Unannounced Secondary Care Inspection</u> The focus of this inspection was to examine 3 standards, including the protection of vulnerable adults. However, due to observations made on the day, only the following two standards were considered • meals and mealtimes and • infection prevention and control. Of the 10 requirements made following the previous inspection on 25 & 26/10/2010 (see No 31 above), 1 was compliant, 2 were moving towards compliance,	In response to a complaint from a relative in February 2011 Complaints Chronology (No 53) about staff shortages, staff sickness being covered up and medicines management, RQIA inspector advised resident's relative that she would follow up the issues raised in her complaint at the next inspection. However this inspection, and the following inspection on 9/05/2011, addressed urgent nutritional issues. There is evidence that only some of the issues in the complaint were investigated.

	Date	Inspection	Review Team Findings / Gaps
		1 was not compliant and 6 were "not reviewed during this inspection". Of the 8 recommendations, one was compliant and the other seven were not reviewed. The inspector noted a considerable number of deficiencies in both standards assessed and stated that a monitoring visit would be conducted within 2 weeks to ensure that the issues raised had been addressed. 13 requirements, covering 20 issues, were made. These included: • Dining arrangements (4 issues) • Care recording - including pressure sore prevention and fluid intake • Staffing levels • Patient protection plans Five recommendations were made, including: • Competency records of staff in charge of CTH • Monthly audit of accidents The inspector spoke with twelve residents and six staff no issues or concerns were raised. The inspector raised concerns about the appearance of some residents and reflected this in the report.	The inspection report format records the inspector's assessment of CTH level of compliance with each standard.
35	9 May 11	<u>Unannounced Follow-up Secondary Care Inspection</u> This inspection found that "some progress had been made" in respect of the issues identified at the previous inspection. The inspectors stressed "the need for prompt remedial action and assurances for sustained improvement" and "highlighted to the	The inspection report acknowledged that a number of requirements and recommendations from the inspection of October 2010 were still outstanding. However, because of the importance of examining the concerns raised at the inspection in April 2011, the report stated that these would be examined at

	Date	Inspection	Review Team Findings / Gaps
		registered manager that enforcement action will be taken if a substantial and sustained improvement was not evidenced during subsequent inspections" (para 1.3) Of the 7 previous requirements reviewed at this inspection, CTH was found to be not compliant in respect of 5, compliant in 1 and moving towards compliance in 1. Of the 4 recommendations reviewed, CTH was not compliant in respect of 3 of these and compliant in 1. The inspection resulted in 13 requirements and 6 recommendations being made. The report noted that the lack of progress in addressing the requirements and recommendations made following the inspection of 20th April 2011 was "of concern". "The outcome of the inspection was discussed with RQIA's head of nursing home and pharmacy regulation, who agreed that further enforcement action may be considered if significant improvement is not observed during future inspections" (page 21). The inspector spoke with twelve residents. All comments about the home were positive and no issues or concerns were raised.	future inspections. CTH response to the QIP was not provided to the review team. The inspector's escalation of her concerns about CTH is to be commended.
36	10 June 11	<u>Unannounced Secondary inspection</u> This inspection was initiated by RQIA's head of nursing home and pharmacy regulation following concerns raised by NHSCT on 9th June that, in the	The review team notes that following this inspection, CTH had a total of 21 requirements and 8 recommendations. Given that RQIA had considered taking further

	Date	Inspection	Review Team Findings / Gaps
		absence of the manager (on sick leave) and a deputy manager, those in charge of CTH may not have the appropriate competencies and capabilities. The inspectors found that arrangements had been made to cover the absence of the registered manger. However they found several deficiencies in the training and supervision of staff. Particular concerns were the absence of records of induction training and the fact that no mandatory training had taken place in 2011. CTH was assessed as non-compliant with Standard 29 – Staff Supervision and Appraisal. Eight new requirements, covering 10 issues were made as a result of this inspection. Two recommendations were also made.	action following the previous inspection on 9/05/2011, (see No 35 above) the review team believe there could have been grounds for enforcement action at this stage. CTH response to the QIP was not provided to the review team.
37	6 September 11	<u>Primary Announced Care Inspection</u> At the time of this inspection, a new manager and a new deputy manager had been employed. The requirements and recommendations made following the previous two inspections (see Nos 35 and 36 above) were reviewed. Of the 21 requirements: • 7 were compliant • 11 were substantially compliant • 2 were moving towards compliance	On 5/09/2011 RQIA received an anonymous letter, from a member of staff, which complained about the new management of CTH. Whistleblowing Chronology (No 41). The Inspector spoke to staff during the inspection and found that this concern was not corroborated.

	Date	Inspection	Review Team Findings / Gaps
		• 1 was not compliant. Of the 8 recommendations: • 4 were compliant • 2 were substantially compliant • 2 were moving towards compliance. The inspection focussed on three standards, including Standard 16 - Patients and Residents are Protected from Abuse. On page 11 of the main report, CTH is stated to be "substantially compliant" with this standard and on page 43 it is stated to be "compliant". As a result of this inspection 14 requirements, covering 25 issues, were made. Many of these were stated for the second time. Requirements included: • Monitoring of fluid intake • Meals and mealtimes (8 issues) • Staff training and appraisal • Care records Four recommendations were also made. Each was stated for the second time. The Inspector spoke to 30 residents, 3 relatives and 10 staff. All comments about the home were positive and no issues or concerns were raised. The QIP was returned from CTH and endorsed "Approved" by RQIA on 20/12/2011.	

	Date	Inspection	Review Team Findings / Gaps
38	Aug-Dec 11	<u>Medicine Information Return</u> CTH submitted the Medicine Information return on 28/10/2011. It contained a self-assessment in respect of four Standards. The Pharmacy Inspector made a telephone call to CTH manager to seek further details and reported: "All arrangements for the management of medicines as detailed in the return and confirmed via telephone (9/12/2011) appear to be satisfactory."	RQIA's inspection methodology changed to a three year cycle, from 2010-2011. In the years when no pharmacy inspection was planned, Homes were asked to complete a medicines information return. This was scrutinised by a Pharmacist who sought further assurance from the Home, if required. Given the outcome of medicines management inspections of CTH since 2005, this process gives minimal assurance that the arrangements were actually "satisfactory."
39	12 June 12	<u>Primary Unannounced Care Inspection</u> This inspection reviewed the requirements and recommendations made following the previous inspection in September 2011. Of the 14 requirements: • 8 were compliant • 1 was substantially compliant • 3 were moving towards compliance • 2 were not compliant. Of the 5 recommendations: • 3 were compliant • 1 was substantially compliant • 1 was not compliant The inspection examined two "Themes" and found that CTH was moving towards compliance of both. Two standards were also examined. In one the	Following receipt of WB's documentation, RQIA wrote to the NHSCT on 1/12/2011: "RQIA during the most recent inspection in September agreed a way forward with the home regarding the inspection outcome taking into account the new management arrangements. We plan to carry out a further inspection of Cherry Tree Private Nursing Home later this month." The inspection took place in June 2012 i.e. 6 months later. This is the first inspection in which "Themes", as well as Standards were inspected.

	Date	Inspection	Review Team Findings / Gaps
		Home was substantially compliant. In the other it was moving towards compliance. The inspection report noted that CTH had established resident / relatives meetings. It was believed that, as a result, there was a low level of complaints. This inspection resulted in 9 requirements, covering 14 issues, including: • Monitoring of fluid intake • Competency records of staff in charge of CTH • Staff supervision and appraisal • Staffing levels • Bed rail risk assessments Three recommendations were also made. The inspector spoke with 20 residents, 2 relatives, eight staff and received two completed questionnaires. All comments about the home were positive and no issues or concerns were raised.	The inspector's action regarding CTH validating the continuing registration of nurses with the NMC is an example of providing good assurance. CTH response to the QIP was not provided to the review team.
40	25 & 29 October 12	<u>Secondary Follow-up Care Inspection</u> The inspection on 25th October identified issues that necessitated a further visit on 29th October by a senior inspector. The concerns included: • The standard of care provided to three patients with particular needs • Staffing levels and skill mix of staff on duty • The competency of the nursing team in several aspects of care • The use of bed rails The inspectors reinforced the seriousness of the issues raised. The report highlighted significant	Review team commends action of inspector for escalating concerns to RQIA line manager.

	Date	Inspection	Review Team Findings / Gaps
		deficiencies of nursing care for a number of residents. The inspection reviewed the requirements and recommendations made following the inspection on 12/06/2012 (see No 39 above). Of the 9 requirements; • 7 were not compliant • 1 was compliant • 1 not validated In respect of all three recommendations, CTH was not compliant. This inspection made 15 requirements, covering 23 issues. These included all the previous requirements and recommendations and issues which had not been addressed during this inspection. Following this inspection RQIA met with the Registered Provider on the 2/11/2012 and on 5/11/012, and issued 4 "Failure to Comply" notices in respect of a number of Regulations of which CTH was in breach. The inspector spoke with a number of residents and two relatives. All comments about the home were positive and no issues or concerns were raised.	RQIA is commended for taking enforcement action.
41	7 January 13	<u>Unannounced Enforcement Monitoring Inspection</u> The focus of the inspection was to assess the progress made in moving to compliance with the four Failure to Comply notices. Full compliance was required by the date of this inspection. The inspector found that, although progress had been made, there were still deficiencies in care planning, care recording, staff training and	

	Date	Inspection	Review Team Findings / Gaps
		supervision which resulted in the Failure to Comply notices being extended until 28/1/2013. In respect of the 15 requirements made following the inspection in October 2012 (see No 40, above): • 5 were compliant • 1 was substantially compliant • 5 were moving towards compliance • 1 was not compliant • 3 were not validated As a result of this inspection, 10 requirements, covering 13 issues, were made. They were all restated previous requirements. The QIP in respect of these requirements was returned from CTH and assessed as acceptable by the inspector on 22/05/2013.	The report provides good assurance as to how the levels of compliance were assessed. However the review team note the delay in receipt of the completed QIP by CTH.
42	28 January 13	<u>Unannounced Enforcement Monitoring Inspection</u> The focus of the inspection was to assess the progress made in moving to compliance with the four Failure to Comply notices. These notices had been extended to the date of this inspection. During this inspection, the inspector observed "significant improvements" and confirmed compliance with the legal requirements in respect of the Failure to Comply Notices. In respect of the 10 requirements made following the previous inspection on 7 January:	

	Date	Inspection	Review Team Findings / Gaps
		• 7 were compliant • 3 were not checked on this occasion As a result of this inspection, 5 requirements were made. These included the 3 requirements from previous inspections which had not been validated at this inspection. The QIP in respect of these requirements was returned from CTH and assessed as acceptable by the inspector on 18/06/2013.	
43	14 March 13	<u>Unannounced Medicines Management Inspection</u> This inspection reviewed the 3 requirements made following the previous inspection in October 2012 (see No 33 above) and found that all three were "moving towards compliance". As a result of this inspection, 6 requirements, covering 9 issues were made. These included; • Training in the management of medicines • Robust audit systems • Personal medication records • Management of the temperature in the medicines refrigerator.	Under the changed arrangements for inspections (see comment at No 38), this was the first medicines management inspection of CTH since October 2010 - 2 years and 5 months previously. The requirements made following this inspection included issues that CTH had failed to address adequately since at least 2005, the need: • for training of staff in the management of medicines, • for robust audit systems • for accurate personal medication records • to properly manage the temperature of the medicines refrigerator.

5.3 Review Team Findings

The review team appreciates that some of its findings apply to historical aspects of the inspection process which are not current practice. The review team is reporting these findings, primarily to fulfil its remit, but also to assist RQIA in any future consideration of its inspection process.

The review team's findings are considered under the following elements of the inspection process:

- RQIA's programme of investigating a number of standards and "themes" each year.
- Pre-inspection planning - including the collection and use of pre-inspection intelligence
- The evidence recorded in inspection reports in respect of:
    - compliance with the standards being inspected
    - compliance with requirements and recommendations from previous inspections
- The inspection report templates
- Quality Improvement Plans
- Enforcement action by RQIA

In addition to the above, we also report our findings in respect of Pharmacy/ Medicines Management inspections and Estates inspections.

5.4 RQIA programme of investigating a number of standards and "themes" each year

RQIA gives providers advanced notice of the particular standards on which inspections will focus each year. Since the publication of the Minimum Care Standards for both Nursing Homes and Residential Homes in 2008, RQIA has been inspecting a number of different Standards each year. Latterly the standards selected have been grouped into "themes".

For example, in 2011-2012, Theme 1 was that "Patients are accommodated in a nursing home which will meet their care needs and ensure that their needs are reviewed regularly". This theme examined aspects of the following Minimum Care Standards:

Standard 3: Admission to the home

Standard 5: Nursing Care

Standard 15: Patients money and valuables are safeguarded

Standard 25: Management and control of operations

RQIA has examined many of the minimum care standards which concern the personal care delivered to residents. However, the review team was concerned to find that the standard on continence (Nursing Home Minimum Standard 19) has never been examined nor has it been included in a theme to be reviewed. The review team note that, while there is a requirement for

Residential Care Homes to have a continence promotion policy, there is no associated minimum care standard.

The review team found that, in several instances, inspections of Cherry Tree House focussed on the programmed standard when it could have been focussed on more urgent matters. An example of this was the inspection held on 14 May 2009 (Inspection Chronology No 26). This inspection took place a few weeks after WB met with the Chair of the Health Committee of the Assembly. On 6 May 2009, RQIA had written to inform DHSSPS that an inspection of Cherry Tree House would be held that month. The letter stated that the inspector "will ensure that the care issues identified in the correspondence [from WB] will be examined during the inspection". While this inspection report was a comprehensive, and concerning, analysis of Cherry Tree House arrangements for infection prevention and control, it failed to address the issues raised with the Chair of the Health Committee.

There were, however, examples when the inspectors became aware of more pressing concerns when they visited the home and they focused on these rather than the standards scheduled to be inspected. For example the inspection of 14 November 2006 (Inspection Chronology No 9) was to examine service user involvement and the management of complaints. However, when the inspector became aware of concerns about staffing levels, the use of bedrails and the need for clinical supervision and staff training, these matters became the focus of the inspection. The review team commends the inspector for addressing these issues which required urgent attention.

5.5 Pre-inspection planning – including the collection and use of pre-inspection intelligence

In planning for an inspection, there needs to be a collation and analysis of pre-inspection intelligence i.e. incidents that have occurred and matters of concern that have emerged since the previous inspection. The investigation of a complaint, or a concern raised with RQIA, may have questioned some aspect of the standards of care provided by a home. In addition to complaints, RQIA receives details of events that are notifiable under Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. The review team believe that the Inspection Planning Tool has the potential to assist in the analysis of pre inspection intelligence.

The review team found that, in a number of instances, there was a lack of evidence that use was made of such pre-inspection intelligence. The review team's analyses of Inspections, Complaints and Untoward Incidents and Whistleblowing provide cross-referenced details of all significant concerns and whether or not there is evidence of the issues raised being examined at the next appropriate inspection.

While there are a number of examples of such issues being raised at subsequent inspections, the review team found that, for several important issues, there is no evidence that these were examined at the next inspection.

1. The report of the inspection held on 21 August 2008 (Inspection Chronology No.22) does not refer to issues which had arisen since the previous inspection:

- Tissue viability and nutritional assessments, raised in January 2008 (Complaints Chronology No 25)
- The series of falls in the Home in April and May 2008 (Complaints Chronology Nos 26 to 28)
- Issues raised in respect of a complaint of a relative to the NHSCT on 28 July 2008 (Complaints Chronology No 30) - weight loss, lack of heat and lack of medical attention

2. Another example of the lack of the use of pre-inspection intelligence appears to have occurred in 2006. In January, February and March 2006, RQIA carried out three "Complaints Inspections" (Complaints Chronology Nos. 4, 5 and 6). These resulted in a total of four requirements, three recommendations and six "improvements" being made. The review team found that RQIA ensured that Cherry Tree House complied with one of the requirements, made after the inspection of 15 February 2006 (Inspection Chronology No. 5). The requirement was for the home to produce an action plan in relation to the training of nurses in the issues of record keeping. However, the review team found that the reports of the next two inspections, on 30 April 2006 (Inspection Chronology No. 7) and 14 November 2006 (Inspection Chronology No.9) RQIA made no reference to the other requirements, recommendations and "improvements" made as a result of the complaints inspections.

Between April and September 2011, RQIA carried out four care inspections of Cherry Tree House. This level of inspection activity reflected RQIA's concerns about this home and was also during this period, in June 2011, when WB met with RQIA and provided detailed statements of her concerns. In a letter in respect of WB allegations, dated 1 December 2011, RQIA informed the NHSCT:

"RQIA, during the most recent inspection in September 2011, agreed a way forward with the home regarding the inspection outcome taking into account the new management arrangements. We plan to carry out a further inspection of Cherry Tree Private Nursing Home later this month".

However the review team notes that, despite this commitment, the next inspection did not take place until 12 June 2012 (Inspection Chronology No 39).

The review team also found that, on occasions, there was no evidence that issues raised by whistleblowers were addressed at the next appropriate inspection. For example, on 13 October 2010, RQIA received a letter from "An Observer, Carrickfergus' (Whistleblowing Chronology No 30). The concerns expressed included:

- Safety and security of residents

- Outings for residents
- Quality of food
- Staff morale
- Racial discrimination
- Management issues
- Lack of staff meetings

An internal RQIA record regarding this complaint noted that an unannounced inspection was planned for 25 and 26 October 2012. However the review team found no evidence in the report of this inspection (Inspection Chronology No. 32) that these issues were addressed.

However, in respect of Pharmacy/Medicines management inspections, the review team found evidence of pre-inspection intelligence being used. For example, the inspection on 26 January 2009 (Inspection Chronology No 25) referred to an earlier incident when a resident had been without prescribed medication for 8 days.

5.6 Evidence recorded in inspection reports

Evidence in respect of compliance with the Minimum Care Standards (2008) being inspected.

Each inspection examined a number of aspects of the care provided in Cherry Tree House. In the vast majority of inspection reports, the review team found that inspectors' conclusions were clearly evidenced. The exception to this was the reporting format used from July 2007 to August 2008 the review team believe was flawed (see 5.7 below).

Evidence in respect of compliance with requirements and recommendations from previous inspections.

An important aspect of each inspection was to examine the action taken by Cherry Tree House to comply with the requirements and recommendations of previous inspections. The review team found that some inspection reports gave good assurance in respect of these issues while a number of reports provided limited assurance.

In some inspection reports, the only evidence recorded that action had been taken, was the oral assurance of the home manager.

- the report of 21 August 2008 (Inspection Chronology No 22) stated on nine occasions "the Registered Manager confirmed that this action was taken", or similar wording. Further, the inspector recorded that Cherry Tree House was now holding staff meetings, but added "minutes and records of staff attendance were not examined during this inspection".

- in the report of the inspection of 14 May 2009 (Inspection Chronology No 26), on a number of occasions the Registered Manager's oral

assurance is followed with the comment “this was not reviewed by the inspector during this inspection”.

The review team believe that these inspection reports gave little assurance that Cherry Tree House had in fact addressed the requirements and recommendations made at previous inspections. The next inspection, on 9 August 2009 (Inspection Chronology No 27), found that, despite the Registered Manager’s previous oral assurances, there was a “lack of progress in relation to complaints investigation, activity provision and policy development” (paragraph 7.0).

However, the report of the inspection on 9 August 2009, (Inspection Chronology No 27) and others, such as inspections held on 5 and 6 January 2010 (Inspection Chronology No 29), contained several statements along the lines of “observations made during the inspection confirmed that the requirement had been met”. These reports provided a high level of assurance.

A further example of an inspection report providing a high level of assurance was that of the inspection held on 12 June 2012 (Inspection Chronology No 39). In this report, in several instances, the inspector detailed the observations she had made to assess compliance with previous requirements and recommendations.

5.7 Inspection Report Templates

Templates for the production of inspection reports are tools to ensure that there is a consistency in the recording of evidence collected during inspections. This facilitates the assessment of the standards being inspected.

The review team found that, over the period reviewed, a number of templates had been used. We found that the templates used from 2009 onwards facilitated the recording of evidence in a way that provided good assurance of the inspector’s assessment of the home’s performance. These templates identified a number of criteria to be assessed for each of the Standards being inspected. The inspector was required to provide evidence for each criterion before making an overall assessment of the home’s performance on the Standard being assessed.

The review team found that the template used from 27 July 2007 (Inspection Chronology No 18) to 21 August 2008 (Inspection Chronology No 21) was deficient. On each issue examined at the inspection, the inspector’s comments are followed by lists of actions the inspector may have undertaken and documents the inspector may have examined. These lists are headed by the words “[e]videnced by all or some of the following”. The review team believes that this inspection report template offered limited assurance as it was not clear what evidence the Inspector had actually used to reach their conclusions. However this was corrected by the time of the Announced Inspection on 8 January 2009 (Inspection Chronology No 23).

5.8 Quality Improvement Plans

Following an inspection, RQIA may determine that there are "requirements" that a home needs to address to be compliant with regulations or "recommendations" linked to the Minimum Standards that a home should consider implementing. If so, the home is expected to complete a Quality Improvement Plan (QIP) pro-forma stating how it has addressed, or intends to address, the requirements and recommendations. When this is returned to RQIA it is scrutinised by the inspector, and, if they find it acceptable, it is placed on file and the inspection report becomes an open report on the RQIA website.[9]

The review team was provided with many, but not all, of the QIPs completed by Cherry Tree House following inspections. On one occasion, following the inspection of 25 and 26 October 2010 (Inspection Chronology No 32), the inspector found the QIP which Cherry Tree House had submitted to be deficient in several places. Cherry Tree House was asked to re-submit the QIP. It did so and the second QIP was found to be acceptable.

When the review team consulted with the Assistant Chief Inspector of Care and Social Services Inspectorate Wales, he told us that it had been decided that it was not an appropriate use of staff time to pursue what he termed "the often fictional action plans" submitted by homes.

In respect of Cherry Tree House the following cyclical scenario was common:

- An Inspection leads to a number of requirements and recommendations being made;
- Cherry Tree House submits a QIP stating that all the issues have been, or would be, addressed;
- The next inspection finds that, in fact, Cherry Tree House has carried out only some of the actions in its QIP; and
- A number of the requirements or recommendations are restated

In the inspection chronology above and in the section on enforcement (below) we report that Cherry Tree House failed to address some requirements and recommendations up to seven times.

5.9 Pharmacy/Medicines Management Inspections

The Review Team's analysis of the Medicines Management inspections shows inspectors seeking to assist Cherry Tree House to achieve acceptable standards.

We have noted that following inspections (Inspection Chronology Nos 11 and 12) and an investigation visit in January and February 2007, Cherry Tree House's management of medicines had improved. Unfortunately, by the time

[9] http://www.rqia.org.uk/inspections/index.cfm

of the inspection on 27 July 2007(Inspection Chronology No18) compliance with the standards had fallen.
The inspector reported:

"Standards in record keeping, administration of medicines and medicine storage and stock control require urgent attention".

The inspector's concerns led to Cherry Tree House being issued with two Failure to Comply with Regulations notices. These notices remained in force until 13 August 2007 when the inspector was satisfied that Cherry Tree House had addressed the issues.

When RQIA moved to a three-year cycle of inspections in 2010-2011, Homes were asked to make Medicine Information Returns in the years that they were not due to have a Medicines Management Inspection. Such a return was provided by Cherry Tree House to RQIA in October 2011(Inspection Chronology No. 38). Following a telephone conversation with Cherry Tree House to clarify some issues, the inspector recorded:

"All arrangements for the management of medicines as detailed in the return and confirmed via telephone (9 December 2011) appear to be satisfactory."

Given the outcome of Medicines Management inspections of Cherry Tree House throughout the period reviewed, the opinion of the review team is that this self-reporting process gave minimal assurance that the arrangements in Cherry Tree House were actually "satisfactory" in December 2011.

The three-year cycle of inspections meant that the next Medicines Management inspection, on 14 March 2013 (Inspection Chronology No 43), took place 2 years and 5 months after the previous inspection on 25 October 2010 (Inspection Chronology No 33). The inspection in March 2013 (Inspection Chronology No 43) found that, despite having had over two years to address the three requirements made in 2010, on all three matters Cherry Tree House was only "moving towards compliance".

The March 2013 inspection (Inspection Chronology No43) resulted in six requirements being made. These included issues that Cherry Tree House had failed to address adequately since at least 2005, namely the need:

- for training of staff in the management of medicines
- for robust audit systems
- for accurate personal medication records
- to properly manage the temperature of the medicines refrigerator.

Despite the efforts of inspectors, the review team was disappointed to note recurrence of the same issues which had not been resolved by Cherry Tree House.

5.10 Estates Inspections

Over the period reviewed there were three Estates inspections - in 2007 (Inspection Chronology No. 20), 2009 (Inspection Chronology No. 24) and 2010 (Inspection Chronology No.31). These inspections resulted in requirements being made in respect of general maintenance, health and safety and fire safety. Over the three inspections, a total of 44 requirements were made. The reports of the inspections in 2009 (Inspection Chronology No 24) and 2010 (Inspection Chronology No 31) made no reference to the requirements made at previous estates inspections. This provided no assurance that Cherry Tree House had complied with any of the requirements made as a result of these three inspections.

5.11 RQIA Enforcement Policy

The review team was provided with the following:

- RQIA Enforcement Policy and Procedure informally dated 3 April 2007.
- The April 2009 and November 2011 revisions of the RQIA Enforcement Policy and Procedure originally adopted on 13 September 2007.
- The Enforcement Policy adopted in March 2013.

The review team's remit was to examine the period January 2005 to March 2103. However, it did not have access to:

- The Enforcement Policy of the Northern Health and Social Services Board Registration and Inspection Unit for the period January to March 2005; or
- The RQIA Enforcement Policy from April 2005 to April 2007.

The review team notes that the RQIA Enforcement Policy of March 2013, when dealing with the consideration of issuing Failure to Comply Notices, is more explicit than the Enforcement Policy of September 2007. The 2013 document states:

"RQIA will always consider issuing a notice of failure to comply when a specific breach has been identified on three occasions in QIPs [Quality Improvement Plans]". Enforcement Policy 2013, Document 2, paragraph 4.2.

The 2007 policy was in place for most of the time reviewed. Both the 2009 and 2011 versions of this policy state that a Failure to Comply Notice may be issued where:

"the RQIA have been unsuccessful in securing improvements in the quality of the service". Enforcement Policy (2009 version) paragraph 14.6.

The review team recognises that the earlier policy was not as explicit as the current policy. However, as noted below, given the repeated multiple failures of Cherry Tree House to comply with Regulations, the review team noted that

there is evidence that RQIA took enforcement action on only 3 occasions in 8 years.

5.12 Enforcement Action in respect of Cherry Tree House

The following table demonstrates the number of requirements made following care inspections to ensure that Cherry Tree House complied with Regulations and it also highlights the number of issues associated with the requirements made following several of the inspections.

Inspection Number	Date	Number of Requirements	Number of issues
1	February 2005	1	
3	September 2005	0	
4	January 2006	1	
5	February 2006	3	
7	April 2006	2	
9	November 2006	13	
10	January 2007	9	13
13	March 2007	5	
15	April 2007	5	
17	April 2007	2	6
19	August 2007	7	10
22	August 2008	10	28
23	January 2009	7	21
26	May 2009	14	67
27	August 2009	7	9
29	January 2010	6	9
30	May 2010	6	
32	October 2010	10	20
34	April 2011	13	20
35	May 2011	13	
36	June 2011	8	10
37	September 2011	14	25
39	June 2012	9	14
40	October 2012	15	23
41	January 2013	10	13
42	January 2013	5	

Over the years reviewed, there are examples of Cherry Tree House failing, on multiple occasions, to address requirements and recommendations made following inspections.

The review team found from 2008 that inspection reports noted when requirements and recommendations were being “restated” - either once, twice or three times. For example the 8 January 2009 inspection (Inspection Chronology No 23) resulted in one requirement, in respect of staff training,

being “restated” and one, in respect of staff supervision, being “restated for a second time”. The review team’s analysis of inspections from 2005 until January 2009 found that this was in fact the seventh time that these matters had been mentioned in requirements because they had not been satisfactorily addressed by Cherry Tree House.

5.12.1 Enforcement Action taken

During the period under review, the review team found that there was evidence that the RQIA took enforcement action in respect of Cherry Tree House on three occasions.

1. On 6 April 2007 an Unannounced Complaints Inspection (Inspection Chronology No 16) was held following the receipt of an anonymous written complaint about care standards and staff shortages. Following this inspection, RQIA wrote to the NHSCT and suggested that the trust should “cease to admit any further patients/residents until there is evidence of stability in terms of staffing”. Following a further inspection on 24 April 2007, (Inspection Chronology No 17) during which an improvement in staffing levels was observed, RQIA wrote again to the trust to suggest that the restriction of admissions be lifted.

The review team is of the opinion that action taken by the RQIA in this instance was timely and effective and it led to Cherry Tree House taking speedy corrective action. The review team note that RQIA chose not to issue a Notice of Failure to Comply with Regulations.

2. On 27 July 2007(Inspection Chronology No 18) a Pharmacy Inspection found that “Standards in record keeping, administration of medicines and medicine storage and stock control require urgent attention”. As a result, on the 31 July 2007 Cherry Tree House was issued with 2 Failure to Comply with Regulations Notices. These remained in force until 13 September 2007 following a further visit when an improvement in compliance was noted.

3. During the inspection that took place on 25 October 2012 (Inspection Chronology No.40), the Inspectors were so concerned about a number of issues that they returned on 29 October 2012, accompanied by a Senior Inspector. The concerns included:

- The standard of care provided to three patients with particular needs
- Staffing levels and the skill mix of staff on duty
- The competency of the nursing team in several aspects of care
- The use of bed rails

The inspectors also reviewed the requirements and recommendations made at the previous inspection, on 12 June 2012 (Inspection Chronology No.39). They found that, of the 9 requirements, Cherry Tree House was compliant in only one and not compliant in respect of seven. (The ninth requirement was not validated at that inspection.) It was also found that Cherry Tree House was not compliant in respect of all three recommendations.

Following the October inspection, and a meeting with the Registered Provider on 2 November, on 5 November 2012, RQIA issued the Registered Provider with four Failure to Comply Notices in respect of Cherry Tree House's breaches of the Nursing Homes Regulations (Northern Ireland) 2005. Cherry Tree House was required to comply with Notices. An Unannounced Enforcement Inspection on that date (Inspection Chronology No 40) found that, although some progress had been made, there were still many deficiencies. As a result, the Failure to Comply Notices were extended until 28 January 2013. At a further unannounced Enforcement Inspection on 28 January 2013 (Inspection Chronology No 41), the inspector found "significant improvements" in respect of the matters covered by the failure to Comply Notices.

The review team commends the action of the inspectors for escalating their concerns to their line manager.

5.12.2 Enforcement Action considered

The review team noted that there was evidence that, while RQIA considered taking enforcement action on 2 occasions, this was not followed through.

1. On 14 May 2009, an Unannounced Inspection (Inspection Chronology No 25) resulted in RQIA making 14 Requirements which detailed 67 separate breaches of regulations. Most of these 67 breaches were in respect of infection prevention and control matters. Ten Recommendations (covering 18 issues) were also made.

Following the inspection, RQIA met with the Cherry Tree House Proprietor to express concerns about:

- Infection prevention and control
- Care Planning
- Policy development
- Staff Supervision
- Complaints management
- Activity programme for patients/residents
- The need for a Deputy Manager to be appointed

The proprietor was informed that RQIA was considering taking enforcement action and Cherry Tree House was given eight weeks to implement improvements.

The next inspection took place on 6 August 2009 (Inspection Chronology No 27). It found that Cherry Tree House had fully addressed only 7 of the 14 Requirements and only 4 of the 10 Recommendations made previously. As a result of this inspection 16 Requirements covering 31 issues (22 of which were in respect of infection prevention and control) were made. One of these requirements was being made for the third time; the other 15 were being made for the second time.

Seven recommendations, covering nine issues, were also made. Many of these were being stated for the second or third time.

Many of these Requirements and Recommendations related to matters which RQIA had discussed with the proprietor following the previous inspection and, about which the evidence indicates that Cherry Tree House had taken little or no action in the interim. In view of this, the review team would have expected enforcement action to have been taken following the inspection of 6 August 2009.

2. Following the inspection held on 9 May 2011 (Inspection Chronology No 35), the report noted that RQIA's head of nursing home and pharmacy regulation "agreed that further enforcement action may be considered if significant improvement is not observed during future inspections" (page 21). This inspection made 13 requirements and 6 recommendations.

A further inspection took place on 10 June 2011 (Inspection Chronology No 36) following concerns expressed by NHSCT staff to RQIA about staffing in Cherry Tree House. This inspection found that Cherry Tree House was "non-compliant" with Minimum Care Standard No 29 - staff supervision and appraisal. This inspection resulted in further 8 requirements (covering 10 issues) and 2 recommendations being made.

The review team notes that Cherry Tree House had, by then, 21 requirements to address in order to ensure it complied with Regulations. We also note that enforcement action was not taken at this stage.

5.13 Enforcement in other Jurisdictions

The Review team is aware that regulators in other jurisdictions within the United Kingdom have reviewed their enforcement policy in recent years. The box below sets out our understanding of the situation in Wales.

The review Team spoke with the Assistant Chief Inspector (ACI) of the Care and Social Services Inspectorate Wales (CSSIW), the body which, inter alia, regulates "Care Homes with Nursing" in Wales.

The ACI told us that following an in depth review of failing services in 2011 they had found that Inspectors had been spending significant time "chasing, often fictional, Action Plans which providers produced after inspections". The CSSIW introduced a new Enforcement Policy in May 2013. Under the terms of this policy:

- Technical breaches of Regulations, isolated failures and recommendations for good practice are noted in the section of the Inspection report entitled "Things this service could do better". . It is assumed that the Provider will address these issues. Providers are notified of areas of non-compliance, and are expected to rectify shortfalls but there is no direct follow up by inspectors.

- More serious breaches of Regulations - those which lead to poor outcomes for services users and / or are indicative of systemic failures - lead to the immediate issuing of "Non-Compliance Notices" which are similar to the "Failure to Comply Notices" in Northern Ireland. These are serious notices and detail the evidence of the breach of the Regulations and the action to be taken by the Provider to remedy the situation. CSSIW do not request action plans, CSSIW require compliance and inspectors undertake follow-up visits to check where necessary.

- A consequence of issuing Non-Compliance Notices is that the provider will be invited for a formal meeting with CSSIW to account for why they are choosing not to comply. Commissioners take note of non-compliance notices (in Wales, the NHS and local councils) and may cease admissions. We also understand that some homes that are subject to Non-Compliance Notices have had difficulties in renewing insurance cover and in their dealings with their bank.

- If a provider does not take corrective action in a timely fashion, or if the breach of Regulations is particularly serious, the Home will be designated a "Service of Concern". Services of Concern are subject to closer scrutiny by a specialist team of enforcement inspectors and are reviewed by senior management in CSSIW on at least a quarterly basis (often monthly). There is an expectation that if a Home is a Service of Concern (i.e. because it remains non-compliant with Regulations) for 12 months, proceedings to de-register the Home will commence.
  We were informed that this new, more robust, enforcement policy is proving to be unpopular with some service providers in Wales. This is because they feel they should be given more opportunity to improve before getting a notice.
  Provider associations have made some representations but CSSIW is standing firm in its approach and it has now become accepted and embedded practice.

5.14 Views of families and others who had reported concerns

Families reported that, while they were aware of when announced inspections were to take place in Cherry Tree House, some suggested that they were unaware that they could speak to inspectors and would have liked the opportunity to do so. Many families were not aware that unannounced inspections also took place.

Others reported that staff were discouraged to report concerns to inspectors. Staff were also reluctant to raise concerns because they knew that inspectors were obliged to report their comments back to management.

Families and others interviewed by the review team raised concerns about the effectiveness of the RQIA Inspection process to detect and address shortcomings in the care provided. They observed a "flurry of activity", e.g. to clean and tidy the home, prior to announced inspections, which they felt gave a false picture about what normally would happen on a daily basis in Cherry Tree House.

Some relatives and others reported their concerns about how thoroughly inspectors checked for evidence during their visits. For example, some relatives reported the frequent shortages of bed linen and continence products. However, others advised the review team that these storage cupboards were locked while RQIA inspectors were on the premises. Some suggested that there might be value in including in the inspection team those who had previously worked in the nursing and residential home sector.

One relative, who had examined the inspection reports during the period her relative was in the home, commented that "inspections resulted in the same requirements and recommendations made to Cherry Tree House year after year". This relative further observed that because issues, including complaints management, were "mentioned in one report and not checked on the next inspection, meant that issues were allowed to continue over a long period of time". She and others believed that inspections did not lead to any improvements in the home. The following comment of one family member was representative of the views of others the review team met - "Why were problems not dealt with and why was Cherry Tree House not closed?"

In addition, some of those who met the review team expressed concern that Cherry Tree House had employed, in senior management roles, staff who had left previous employment following their practice being called into question. Families commented that it was too easy for staff who had been dismissed in one home to move to another. They felt that there are inadequate controls in place to prevent this happening.

5.15 Comments and Recommendations

In the analysis above, the review team has been critical of some aspects RQIA's inspection methodology and practices and including RQIA's limited use of enforcement powers. However, over this eight year period, the reports of inspections clearly demonstrated that Cherry Tree House was failing to comply consistently with Regulations and minimum standards of care.

In light of this analysis of the inspections of Cherry Tree House undertaken over the period of the review, and feedback from families and others, the review team makes the following recommendations.

15 RQIA, as a matter of urgency, should ensure the DHSSPS Nursing Homes Minimum Care Standard on Continence Management (No 19) is included regularly in the programme of inspections.

16 In order to assist in the inspections of homes where there are concerns about standards of care, RQIA should consider recruiting, as Lay Assessors, Staff Nurses and Care Assistants who have worked in Nursing Homes.

17 Inspectors should adequately prepare for inspections by gathering and analysing all available information in respect of complaints, untoward incidents and the concerns of whistleblowers and evidence this in inspection reports.

18 Inspection staff should review all intelligence prior to inspections and be given the flexibility to deviate from the planned programme of inspection to address areas of concern.

19 During inspections, inspectors should source directly the evidence of compliance with standards and previous requirements and recommendations and should not rely on others to provide assurance.

20 RQIA should consider how it can more effectively ascertain the views of residents, families and staff during inspections.

21 RQIA should review its enforcement policy and procedures in light of developments in other jurisdictions.

22 DHSSPS should review the Nursing Homes Minimum Care Standard (No 24) in relation to Recruitment of staff, to ensure proper controls and checks are in place to prevent staff, whose practice has been called into question, being able to move easily between homes.

6.0 Conclusions

The provision of good quality care for older people in nursing and residential homes is a major challenge for modern society. Elements to ensure such care include:

- Nursing and residential homes which are focused on delivering the fundamental aspects of care through appropriately trained staff;
- Local commissioning of high quality services through person centred care planning;
- Robust and responsive regulation to ensure the minimum care standards are maintained; and
- Family members and others, including staff, who are empowered to act as advocates for those older people who are unable to speak for themselves.

The review team found evidence of good practice by those responsible for monitoring the care provided by Cherry Tree House and also evidence of families and staff raising concerns about that care. However we found that aspects of each of the four elements, above, failed at times during the period reviewed.

As a result of reviewing in detail the complaints, untoward incidents, whistleblowing and inspection reports, the review team conclude that Cherry Tree House was failing to comply consistently with the minimum care standards. There was evidence that the same issues of concern about care at Cherry Tree House were highlighted on a regular basis and where improvements were made, they were often not sustained.

In line with current policy, in respect of complaints regarding elderly residents, the Northern Trust relied on Cherry Tree House management to provide the assurance regarding the quality of care. Trusts should review their monitoring and assurance processes to ensure that complaints about their residents are appropriately managed and resolved.

While RQIA's inspection reports highlighted shortcomings in the care provided at Cherry Tree House, the review team conclude that there were opportunities for RQIA to take a more rigorous approach to the enforcement of Regulations and Minimum Care Standards. In addition, the failure to consistently use the "intelligence" available about Cherry Tree House, led to fundamental aspects of care not being reported on in the inspection reports.

Families and others communicated their lack of understanding in escalating complaints about the care in Cherry Tree House to external bodies. They did not understand the roles and responsibilities of health and social care organisations in respect of handling complaints. They had limited knowledge of support available to complainants.

The review team found that staff who raised concerns felt they had received little support from Cherry Tree House and the external bodies they contacted.

The main whistleblower, frustrated by the apparent lack of response to her concerns, felt obliged to raise these issues with the Minister.

The review team hopes that this report and recommendations will lead to improved nursing and residential home care provision for older people in Northern Ireland.

7.0 Summary of recommendations

This section is a collation of the review team's recommendations previously stated in sections 3, 4 and 5. These have been designed to help organisations address the issues that have led to this review.

Complaints and Untoward Incidents

1. The regional contracts for residential and nursing home care should be amended to require homes to report each complaint about the care of residents and the outcome of the internal investigation.

2. Trusts should ensure that there is a mechanism for communicating such complaints to those trust staff who are responsible for reviewing the care of residents.

3. Trusts should seek assurance at their contract review meetings with homes, that for the complainant all complaints issues have been addressed.

4. In order to improve the accessibility and quality of Information about making a complaint, the following should be considered:

    - Trusts' information packs for prospective residents and their carers should include details of how to make a complaint;

    - New residents and their families should be provided by homes with information on making a complaint. Such information should be both in the admission pack and on display in the home; and

    - All information, regardless of source, should include reference to the role of the Patient Client Council in providing support and advice to complainants.

5. The quality of investigations should be enhanced by investigators:

    - Speaking to the complainant to clarify the issues of concerns; and

    - Interviewing all care staff who might be able to contribute to the process.

6. Vulnerable Adults strategy meetings should clearly identify those individuals who need to be interviewed.

7. All organisations should ensure feedback to complainants is accurate and timely. They should seek assurance that the complainant is satisfied with the handling of their complaint.

Whistleblowing

8 The Northern Ireland Executive should review the Public Interest Disclosure (N.I.) Order 1998 in light of the recommendations of the Whistleblowing Commission's report of November 2013. Of particular relevance are the following:

- The licence or registration of organisations which fail to have in place effective whistleblowing arrangements should be reviewed. (Recommendation 3)

- Regulators have a clear procedure for dealing with whistle blowers who come to them, including the provision of feedback, and explaining when it is not possible or reasonable to do so.(Recommendation 4)

- Regulators include whistleblowing in their annual reporting mechanisms, including in accountability hearings before Parliament. (Recommendation 5)

9 The Minister should seek assurance that all HSC organisations have robust whistleblowing policies and procedures which reflect the spirit of his letter of 22 March 2012.

10 The DHSSPS should consider implementing best practice in other jurisdictions in relation to the protection of whistleblowers.

11 Each HSC organisation should consider nominating a non-executive director as champion for whistleblowing issues.

12 RQIA should assure itself that, in line with existing Minimum Care Standards, all residential and nursing homes have in place a whistleblowing policy that includes support and protection for whistleblowers.

13 RQIA should assure itself regularly that it complies with its Guidance for Whistleblowers (October 2013).

14 Updated training on whistleblowing should be provided following any change in legislation or policy. This should promote both a culture and environment which encourage staff to feel able to raise concerns about health and social care matters. Such training should be mandatory for all staff and be an integral part of a regional awareness campaign.

Inspections

15 RQIA, as a matter of urgency, should ensure the Nursing Homes Minimum Care Standard on Continence Management (No 19) is included regularly in the programme of inspections.

16 In order to assist in the inspections of homes where there are concerns about standards of care, RQIA should consider recruiting, as Lay Inspectors, Staff Nurses and Care Assistants who have worked in Nursing Homes.

17 Inspectors should adequately prepare for inspections by gathering and analysing all available information in respect of complaints, untoward incidents and the concerns of whistleblowers.

18 Inspectors should review all intelligence prior to inspections and be given the flexibility to deviate from the planned programme of inspection to address areas of concern.

19 During inspections, inspectors should source directly the evidence of compliance with standards and previous requirements and recommendations and should not rely on others to provide assurance.

20 RQIA should consider how it can more effectively ascertain the views of residents, families and staff during inspections.

21 RQIA should review its enforcement policy and procedures in light of developments in other jurisdictions.

22 DHSSPS should review the Nursing Homes Minimum Care Standard (No 24) in relation to Recruitment of staff, to ensure proper controls and checks are in place to prevent staff, whose practice has been called into question, being able to move easily between homes.

Glossary of Terms and Abbreviations

ACI	Assistant Chief Inspector
BHSCT	Belfast Health and Social Care Trust
C/A	Care Assistant
CEx	Chief Executive Officer
CTH	Cherry Tree House
DEL	Department of Employment and Learning
DHSSPS	Department of Health and Social Services and Public Safety
DFP	Department of Finance and Personnel
MP	Member of Parliament
MLA	Member of the Legislative Assembly
HPSS	Health and Personal Social Services
HSC	Health and Social Care
NIHRC	Northern Ireland Human Rights Commission
NISCC	Northern Ireland Social Care Council
NHSCT	Northern Health and Social Care Trust
PCC	Patient Client Council
PCaW	Public Concern at Work
PHA	Public Health Agency
PSNI	Police Service Northern Ireland
RGN	Registered General Nurse
RQIA	Regulation and Quality Improvement Authority
S/N	Staff Nurse

Appendices

Appendix 1: DHSSPS letter of Commission

From the Chief Medical Officer
Dr Michael McBride

Department of
Health, Social Service and Public Safety
www.dhsspsni.gov.uk

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Your Ref:
Our Ref:
Date: 9 September 2013

Dear Glenn

CHERRY TREE CARE HOME

Introduction

The purpose of this letter is to commission a review from RQIA regarding Cherry Tree Care Home which is located in the Northern Trust. The primary function of such a review is to ensure that all necessary steps have been taken retrospectively in light of whistleblower and other allegations over many years.

Detail

Cherry Tree is a large purpose-built nursing and residential home which is registered to provide care for persons with dementia, learning disability or physical disability. Allegations have arisen over many years and, in such circumstances, one of the main issues relevant to this review will be a desktop collation of information sources including the Trust, HSC Board, Department and RQIA itself. More recently the Northern Trust has completed an internal review of the Trust response to allegations and has documented actions/outcomes against each known allegation.

Nature of Allegations

Most of the allegations arise from "whistle blowing" by staff to external parties, complaints raised by families, and concerns raised by the Trust itself. The Department has paperwork pertaining to this home as far back as 2006.

Broadly, the allegations relate to:

- Unacceptable standards of care;
- Specific incidents relating to maltreatment/abuse of individuals;
- Alleged failure of organisations, including service regulators, to safeguard vulnerable adults; and
- Various employment issues relating to staff members.

There have been a number of adult safeguarding investigations in respect of specific allegations of abuse, some of which have involved the PSNI. In addition, RQIA has completed a number of inspections of this home. In November 2011, the Trust advised RQIA that it would work with the new manager of the home in moving forward and would not keep revisiting previous issues. However, given the long history of allegations the Department's aim is to seek external assurance that all appropriate actions have been taken, as past action or inaction can have consequences for the future; to this end, the collation and evaluation by RQIA of all identifiable, relevant information from the range of sources held within Trusts, DHSSPS, RQIA and other involved organisations will be important.

We understand that a complaint may be made to the Ombudsman concerning this home in the near future.

Conclusion

I should be most grateful if RQIA could now institute the required review as documented in the attached terms of reference, paying particular mind to the requirement for independence.

Yours sincerely

DR MICHAEL McBRIDE
Chief Medical Officer

Enc

cc: Paul Cummings
Mary Hinds
Andrew McCormick
Michael McBride
Catherine Daly
Angela McLernon
Maura Briscoe
Joyce Cairns
Linda Devlin
Ronan Henry
Fergal Bradley
Michael Sweeney
Neil Magowan
Dean Looney
Conrad Kirkwood
Paul McConville
Jackie McIlroy
Brian Taggart

The Regulation and Quality Improvement Authority

Review of the actions taken in relation to concerns raised about care delivered at Cherry Tree House (Nursing and Residential Care Home)

Background

Cherry Tree House in Carrickfergus is registered with RQIA as a residential care home and also as a nursing home. This review has been commissioned by the Department of Health, Social Services and Public Safety (DHSSPS) to review the actions which were taken by statutory bodies in response to whistle-blower and other allegations in respect of Cherry Tree House (Nursing and Residential Care Home) since 2005.

Concerns in respect of Cherry Tree House have arisen since 2005 from whistle-blowing allegations by staff to external parties, complaints raised by families and concerns raised by the Northern Health and Social Care Trust (the Trust area in which the home is situated). In addition, RQIA has taken regulatory enforcement action following inspections of the facility.

Although investigations have been conducted, it is not clear, at this stage, whether all concerns/allegations were investigated – this is because there was a wide range of organisations/individuals and data sources involved. Therefore, RQIA has been commissioned to carry out a review to provide independent assurance that all necessary steps have been taken in response to concerns arising over this period. The review has been commissioned under Article 35(1)(b) of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and will cover the period 1 January 2005 to
31 March 2013.

During this review, in order to provide ongoing assurance that the care provided is safe for patients and clients, the facility will continue to be subject to inspection by RQIA. This will be carried out through normal regulatory activities, in accordance with The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and associated regulations.

RQIA will engage a review team with relevant experience and who have not previously engaged in work around Cherrytree. Key professionals for the team will be sought from sources external to RQIA.

A report setting out the findings in relation to the terms of reference set out overleaf will be provided for the Minister for Health, Social Services and Public Safety by 30 November 2013.

Terms of Reference

1. To collate and deliver a chronology of the evidence, allegations and/or disclosures (both anonymous and attributable) made to external parties relating to the care at Cherry Tree House, including concerns:

    - raised by families
    - raised by former and existing staff members, or
    - brought to the attention of relevant bodies including, DHSSPS, Health and Social Care (HSC) Board, HSC trusts, PSNI and RQIA.

2. To prepare a chronology of all actions taken by relevant organisations in response to this evidence, allegations or disclosures to share information, investigate allegations and take forward the requirements and/or recommendations of any subsequent reports or regulatory activity.

3. To identify if there were any gaps or deficiencies in respect of the actions taken in response to the evidence, allegations or disclosures by any of the bodies, and make recommendations to address issues identified from this analysis including those around working together.

4. To identify any learning from the actions taken, and make recommendations to take this forward.

In undertaking the investigation, and in the drafting of the Review Report, the Review Team will work within the RQIA governance framework, with particular reference to issues relating to information governance, client confidentiality and data protection.

Appendix 2: Summary of Changes to RQIA Inspection Methodology

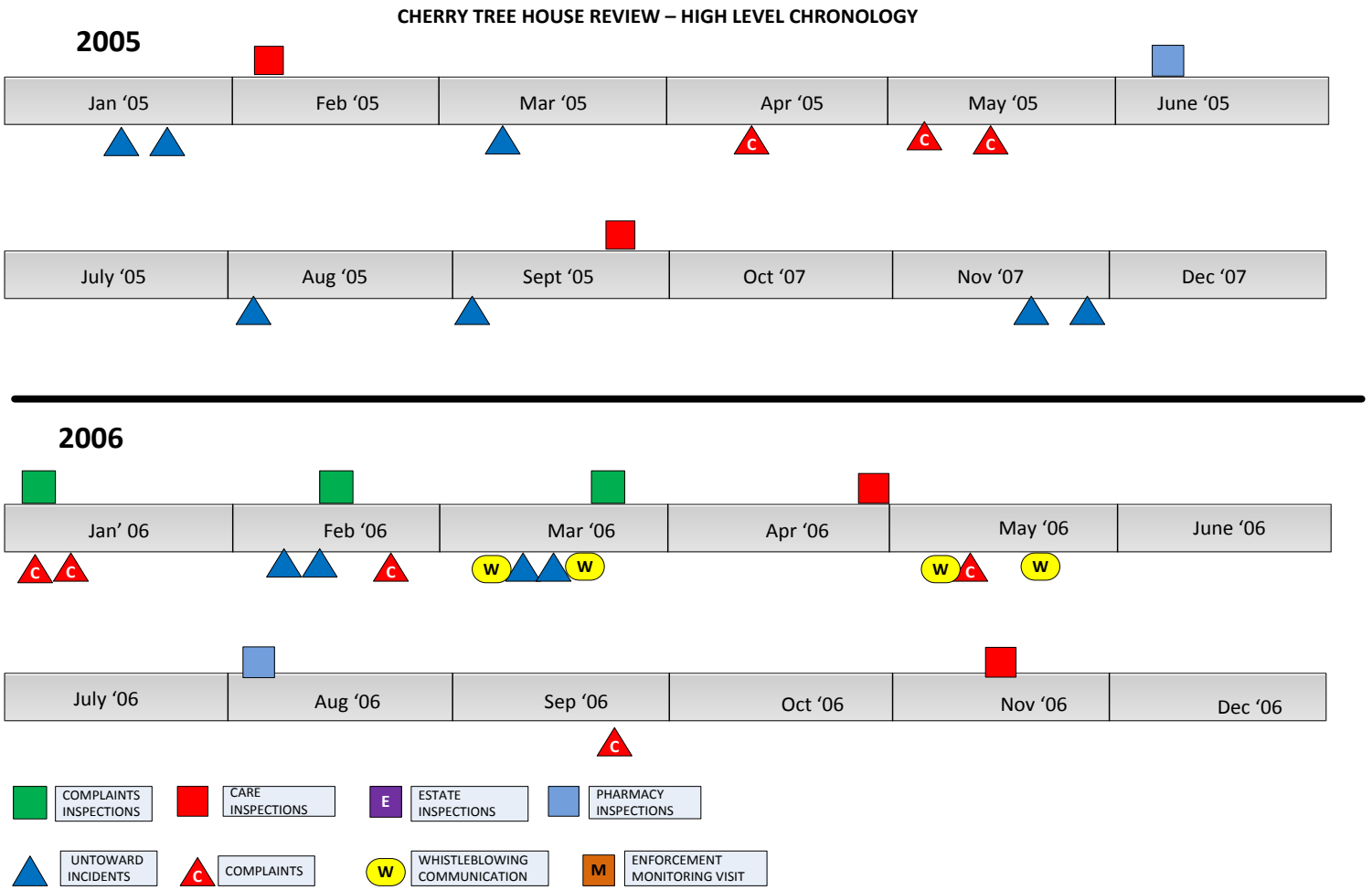
Summary of changes in RQIA's Inspection Process: 2004 - 2013	
2004/05	The inspection of residential and nursing care homes was carried out by the four Registration and Inspection Units (R&I Units) based within each of the four H&SS Area Boards. Historically, an inspection of a regulated establishment considered the broad range of requirements as set out in the legislation. Each R&I Unit had processes in place should breaches of the legislation require enforcement action. Legislation in place: • The Registered Homes (Northern Ireland) Order 1992 • The Nursing Homes Regulations (Northern Ireland) 1993 • The Residential Homes Regulations (Northern Ireland) 1993 Between 2004/05 and 2008/09 care inspections within nursing and residential care homes focused on four main areas: Quality of Care Quality of Living Quality of Management Quality of Environment 2005: New legislation implemented: • Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 • The Nursing Homes Regulations (Northern Ireland) 2005 • The Residential Care Homes Regulations (Northern Ireland)2005 The four Area Board R&I Units became one new independent organisation on1st April 2005: The HPSS (NI) Regulation & Improvement Authority. Inspection and regulation activity continued during the period of transition and under the above new legislation for nursing and residential care homes. During the transition, practice in regard to inspection consisted of a range of approaches inherited from the previous R&I Units. This broad brush approach, whilst meeting statutory requirements, did not provide robust assurance that registered services were delivering the quality of care and services expected.. There was early recognition of the need to consolidate and enhance RQIA's regulation practice and the need to harmonise existing policies and procedures with a view to further development.

	Regulation practice was changing across the UK, these changes being influenced heavily by regulation developments both in health and social care and in government policy direction. As a result, RQIA commenced work to develop a new inspection methodology based on the principles of good regulation. The principles are: Transparency - aim is to provide clear information to registered providers and managers. Targeting - resources are effectively deployed on services that are most at risk of failing to meet required minimum standards. Proportionality - enforcement action to be in proportion to risk identified and the action required to make improvement. Consistency - consistent approach towards regulation of registered establishments. Accountability - for actions taken in carrying out regulatory duties.
2006/07	The DHSSPS was developing minimum standards for a range of regulated services including nursing homes. The purpose of the standards was to specify the arrangements, facilities and procedures that needed to be in place and implemented by registered providers to ensure the delivery of a quality service. RQIA launched a public consultation on a proposed new methodology for the inspection of regulated services, with a view to gradually introducing new ways of inspecting and reporting on the quality of these services. The consultation also highlighted the fact that the accountability and responsibility for the provision of quality services rested with providers. RQIA recognised that regulators should be drivers of quality rather than merely compliance and continued to revise its inspection approach to focus on a range of prioritised criteria.
2008/09	The Inspection Improvement Project (2008) progressively introduced changes in an incremental manner to improve regulatory effectiveness for example: • Focus on performance indicators and grading/rating of the performance of individual service providers to provide clearer information to the public and commissioners • Reinforcement of providers' responsibility for quality by the development of self-assessment approaches. RQIA reviewed the enforcement procedure against the new legislation and a revised Enforcement Policy and Procedure was introduced in 2009 which outlined 'a stepped approach to enforcement'. The Enforcement policy/procedure states: A decision to issue a Failure to Comply Notice is usually taken after:

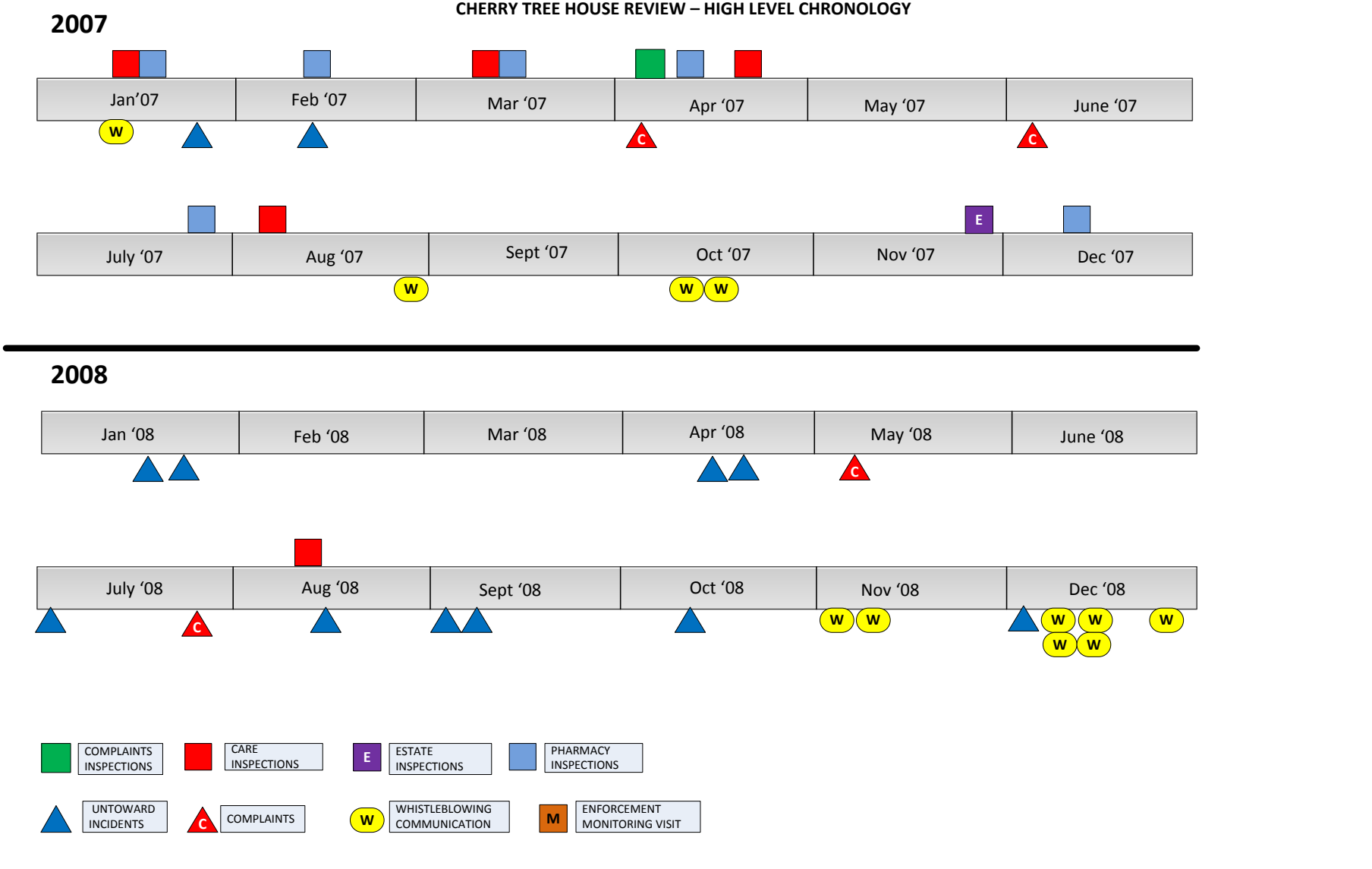
	• The RQIA has been unsuccessful in securing improvement in the quality of service • When the registered person has failed with legislative requirements or fails to comply with an improvement notice and the non-compliance is linked to a breach of regulations • The service being provided is considered to place the health, welfare and safety of service users at immediate risk. As part of the inspection/regulatory process, Inspectors seek advice from their line manager regarding any issues and/or concerns about the quality of a service or establishment. Depending on the situation and the assessment of risk, it may be appropriate to convene a meeting with the Registered Person/Registered Manager and/or increase inspection activity to encourage and support required improvements. Further enforcement action may be taken where there is a continued lack of compliance or progress made to improve the quality of care and delivery of the service.
2009/10	Changes to the complaints process: Complaints in Health and Social Care (HSC) 1 April 2009, made a significant difference to RQIA's ability to scrutinize alleged serious failures in care provision. RQIA was no longer responsible for investigating complaints in the form of a complaints inspection. The emphasis was on local resolution and the reporting of these findings to RQIA. RQIA would inspect in circumstances where a complaint involved a possible breach in regulations that could pose a significant risk to service users. RQIA held the first annual Provider Road Show to inform providers about the changes to the inspection methodology.
2010/11	Project Group established to further develop RQIA's inspection methodology with a focus on introducing a risk assessment approach for inspection.
2011/12	During the 2011/12 inspection year, RQIA implemented an Inspection Planning Approach based upon a risk assessment of information about the establishment such as: handling of vulnerable adults concerns; management changes within the home; arrangements for assessing and reviewing care needs. The inspection planning tool was designed to assist inspectors to decide on the frequency and intensity of an inspection to a particular establishment, agency or service and to intensify inspection inputs to services were concerns are identified. It also allowed managers to make informed decisions regarding the use of staff resources whilst ensuring that statutory targets continued to be met.

	This risk assessment is undertaken at least annually following the primary inspection of the year and is ongoing as appropriate through the inspection year when other significant information is received about the service. For example, in the form of complaints, whistle blowing or notifiable events. For those homes requiring two inspections, the second inspection could be undertaken as: care, estates, pharmacy or finance. For those homes that require only one statutory inspection (Agencies and Day Care) the risk assessment may have identified concerns that required a further follow up care inspection and/or a specialist inspection and this is above the minimum requirement. Specialist inspections across all regulated homes are on a cycle of one pharmacy and estate inspection in every three years. The cycle for finance inspections is less frequent and inspections largely focus on matters identified during care inspections. The implementation of the provider self-assessment and changes to the inspection report format. Full inspection reports began to be made available on the RQIA website. Introduction of an annual procedure to select service type priority themes and standards for the future inspection year. The prioritised themes and standards for announced inspections are clearly identified to service providers in advance of the annual inspection. Themes are outcome focused and are related to the quality of care and experience of the service user. Particular themes are identified on an annual basis and are informed by previous years' experience of regulating within the sector. Example of a theme (2011/12). Patients are accommodated in a nursing home which will meet their care needs and ensure that their needs are reviewed regularly. The theme is examined within the home by focusing on aspects of the following minimum standards: Standard 3: Admission to the home Standard 5: Nursing Care Standard 15: Patients money and valuables are safeguarded Standard 25: Management and control of operations There was further development of RQIA's Enforcement policy and procedure.
2012/13	Five day Inspector training for all inspectors and line managers across a range of topics related to inspection and regulatory activities. Further option for attaining a certificate of training available to inspection staff.

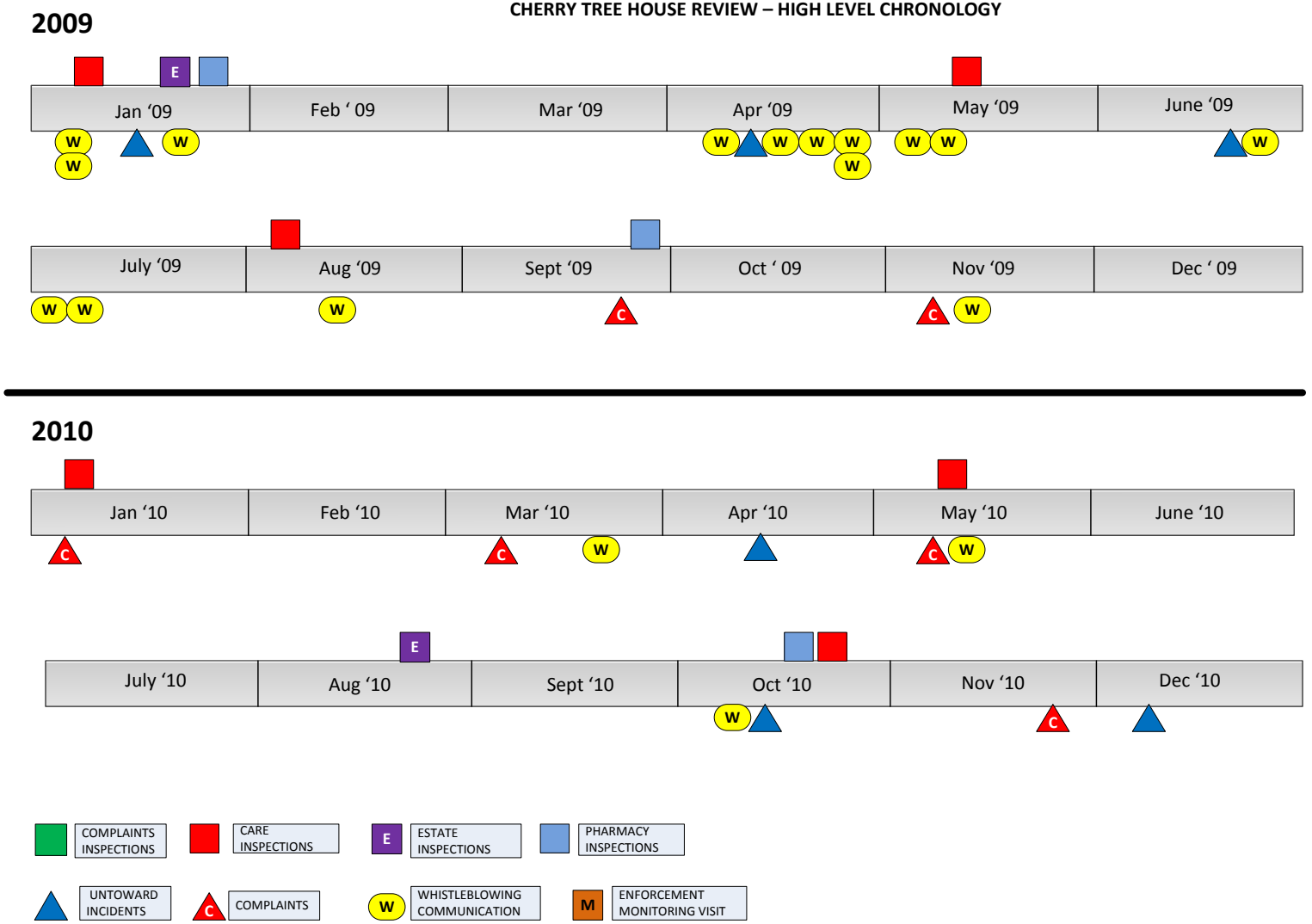
Appendix 3: Graph of Chronologies



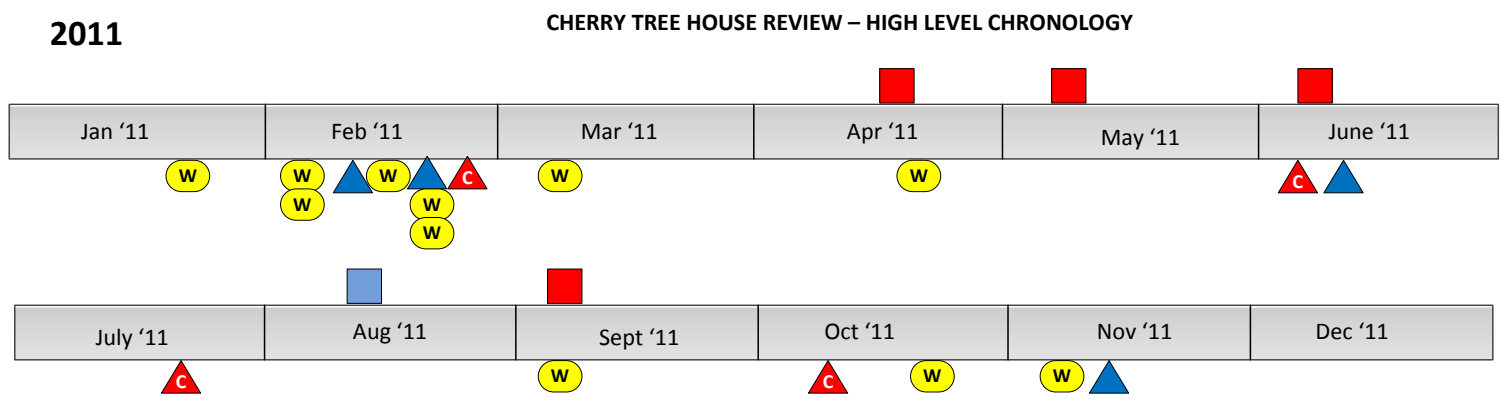
CHERRY TREE HOUSE REVIEW – HIGH LEVEL CHRONOLOGY



CHERRY TREE HOUSE REVIEW – HIGH LEVEL CHRONOLOGY

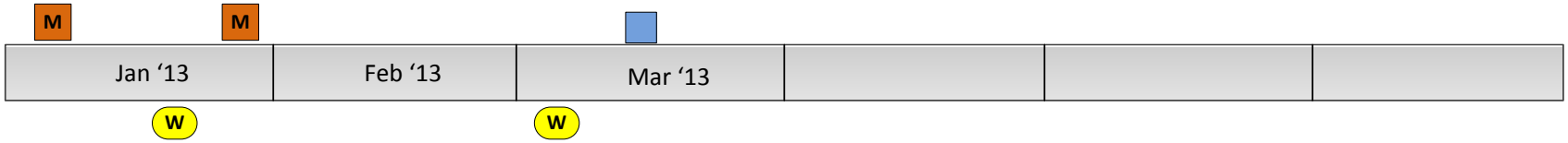


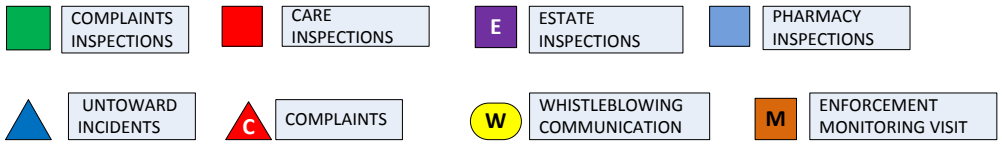
CHERRY TREE HOUSE REVIEW – HIGH LEVEL CHRONOLOGY



CHERRY TREE HOUSE REVIEW – HIGH LEVEL CHRONOLOGY

2013





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