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Care Quality Commission
Re: The inquest into the death of John Gwynfryn Morris

Dear Mr Thomas

We write in reply to your further letter and to the additional questions that you kindly invited the Commission to consider and clarify.

Before addressing those questions we would like to reiterate our sadness and great concern about the issues that were raised in your report about the circumstances leading to Mr Morris' death. We also wish to emphasise our very real commitment to address the concerns raised in your report, and to assist in improving the care provided not only generally but also with specific regard to patients living with dementia. We would also like to apologise for the delay in providing our response which has been due in part to careful consideration being given to changes that are currently taking place within the Commission in terms of its structure and the regulatory framework which underpins the our functions.

In response to your questions we attempt to clarify our response as follows:

1. The Commission agrees that the extra care that is required for people living with dementia is sometimes underestimated by providers. The Commission is also very conscious of the difficulty in assessing the staffing needs for people that live with dementia. For that reason when we are inspecting against the relevant staffing regulation[1] we do not only assess care plan records but also talk to staff as well as patients and relatives where possible. When we inspect care plan records we would expect to see a care plan for a person's needs at night, and particularly if that person had been assessed as needing support at night. During the course of an inspection visit we are only able to assess and track a selection of peoples' care pathways. That does regrettably raise the

[1] Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

possibility that the selection does not incorporate someone who has complex needs at night. However, as part of the inspection planning process we do take into account of intelligence that would help to focus the inspection, where for instance concerns about the levels of staffing are raised. That intelligence would include any notifications of incidents or injuries that providers are required to notify us of, as well any concerns or complaints that have been shared with us, and as a result of liaising with the local authority and the Clinical Commissioning Group.

2. The care provided to people that live with dementia is taken extremely seriously by the Commission. Greater focus is being given to the ways in which we can improve the Commission's regulation of providers that offer care to people with dementia. As part of that development between December 2013 and February 2014 a themed programme of inspection on the quality of care for people with dementia took place. That programme focussed in particular on the experiences of people with dementia as they move between hospitals and care homes. The programme involved inspections of 150 hospitals and care homes in 22 different local authorities. Understanding the experience of people with dementia, their families and carers has been the main focus of the review. The Commission is also working with a number of dementia organisations to help inform and improve our approach to regulation by enhancing understanding of what works, what doesn't work and how dementia care can be improved. Those organisations include the Dementia Action Alliance, Dementia Advocacy Network, Age UK, the Race Equality Foundation and local Healthwatch agencies. The results of that programme not only includes the publication of individual inspection reports but will also involve the production of a national report in May or June 2014 setting out the good practice that we have found together with improvements that can be made to dementia care across different services. Consideration of staffing levels will form part of that report.

3. The Commission has also sought to improve its own staff's understanding of dementia by implementing Dementia Awareness Training. That training has been delivered by the Alzheimer's Society and comprised mandatory training for all Commission staff to gain and consolidate knowledge, skills and support in order to appreciate better the impact of dementia on people's experience of care and to incorporate that into our regulatory activities. That training has been delivered by internal trainers accredited by the Alzheimer's Society and has had the following objectives:

    - To raise awareness of the condition, including the signs and symptoms of dementia;
    - To recognise the possible physical and mental experience of those living with dementia;
    - To understand the potential impact of the condition for carers;
    - To recognise the uniqueness that a person's experience of living with dementia may be; and
    - To increase awareness of the support available to those living with dementia and their carers.

4. In terms of night time inspections the Commission does currently carry out inspections at night if we have a concern about the care being provided at night, and we will be undertaking more out-of-hours inspections in the future. Satisfying ourselves of the compliance of a service provider over 24 hours is something that is being given careful consideration and is likely to change as our methodology changes. Following the inquest into the tragic death of Mr Morris, and the concerns that were raised into care at night, an inspection was undertaken at Willowthorpe Care Home during the evening of 3 March 2014. The resultant report was published on 20 March 2014 and can be found on the Commission's website, www.cqc.org.uk. For completeness we enclose a copy of that report to this letter. However, we also set out the relevant section dealing with staffing levels below:

   "Our judgement

   "The provider was meeting this standard.

   "There were enough qualified, skilled and experienced staff to meet people's needs.

   "Reasons for our judgement

   "We inspected Willowthorpe because we had received concerns that there were insufficient numbers of staff available to meet people's needs, and keep people safe at night.

   "During our inspection on 03 March 2014 we found there were enough experienced staff to meet people's needs at night. Overall we found that there was a calm atmosphere in the home, buzzers were answered in a timely manner and people were not calling out for help. Staff appeared calm and organised. There were a group of people still up socialising in the lounge when we arrived at the home. People in the residential unit were able to talk with us and said they were happy with the time they went to bed and were able to choose when this was.

   "We spoke with two members of staff, two people who used the service and looked at the night care records for two people who used the service. The manager provided us with records of the training undertaken by two of the night members of staff subsequent to our visit. This demonstrated to us that staff had received regular training in areas such as moving and handling, dementia care, administration of medicines and safeguarding.

   "Willowthorpe provides care to people in two separate units. We found that one senior and one carer per unit provided support during the night to people, and they were usually supported by an additional carer between 4pm and 10pm in the evening. People we spoke with told us that there were sufficient numbers of staff available to provide their care and support.

   "However, the provider may find it useful to note that on the night of our inspection one carer had called in sick at short notice and their shift had not

been covered. We looked at the rotas for the preceding week and noted this was a one off occurrence. Staff we spoke with during our inspection told us that although they were busy they felt they were able to support people's needs appropriately.

"We looked at the care records for two people who used the service who were at risk of developing pressure sores. We then checked they received the care during the evening that had been documented as required. For one person who used the service we found they had been placed on an appropriate air flow mattress and the setting was appropriate for their needs. However, we found for another person that the setting was very slightly too high for their weight. We discussed this with the manager the following day. They told us that staff had provided feedback to them at handover and that they had adjusted the setting. They told us that they had also spoken with the carer regards air flow mattress settings and this was to be discussed with all staff in a team meeting.

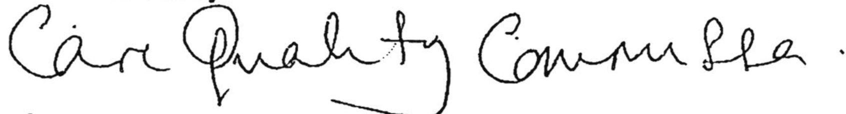
"The two people's care records we looked at identified that they required two hourly repositioning during the night. Staff confirmed they checked and repositioned them every two hours during the night, applying cream to areas at risk of pressure ulcers. The charts in people's rooms confirmed that this took place. Staff told us that they also carried out two hourly checks of all people in the dementia unit, and would provide support to people if this was required. Staff we spoke with told us that they offered people drinks and provided personal care as needed. Records we looked at for one people showed us that they had received a minimum of two hourly checks with frequent hourly checks and care provided.

"As we toured the building we found that the patio door leading to the outside from the lounge on the dementia unit could be opened from the inside. We opened the door and an alarm sounded. The staff reacted immediately to the door alarm sounding and came to investigate. We also checked another door on the dementia unit and found this to be alarmed. This meant that at night there were sufficient numbers of staff and safety measures in place to ensure people at risk of wandering did not leave the home."

5. Regrettably, it is extremely difficult for the Commission to say definitively whether two members of staff were sufficient in numbers in a unit where people with dementia were resident in the circumstances of this very sad case. Those circumstances would include the layout of the home, the needs of the service users at the home at the time, the skills and experience of the members of staff that were on duty and what the staff that were on duty were required to do. Nevertheless, as we have endeavoured to set out above we are proposing to publish a national report in May or June 2014 which will set out the good practice that we have found together with improvements that can be made to dementia care across different services. Careful consideration of the sufficiency of staffing levels will form part of that assessment and will shape improvements that we make in terms of our approach and methodology for regulating providers that care for people with dementia.

We hope that the contents of this letter address the areas on which you sought further clarification. Please do not hesitate to contact us if we can be of any further assistance.

Yours faithfully



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