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Dr Fiona J Wilcox
HM Senior Coroner Inner West London
Inner West London
Westminster Coroner's Court
65 Horseferry Road
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20 March 2017

Care Quality Commission
Our Reference: [redacted]

Prevention of future death report following inquest into the death of Mrs Winifred Elliott

Dear HM Coroner

Thank you for your letter dated 15 December 2016 in which you wrote to us under the provisions of Regulation 28 of the Coroners (Investigations) Regulations 2013 in relation to the inquest into the death of Winifred Elliott.

Further to your report referenced above, we are writing to you with our response to the issues raised. Before addressing in turn each of the concerns set out at section 5 of your report, we set out a background which I hope will assist, providing context to the actions that we have taken.

Background

CQC was notified on 5 January 2016 of the injuries sadly suffered by Mrs Elliott at Meadbank Care Home by the provider under Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We were informed that Mrs Elliott had been transferred to hospital and that a safeguarding alert had been submitted to the local authority as there were concerns about how the injuries had occurred. There were no ongoing concerns about the service at the time of the incident and the lead inspector for Meadbank Care Home was in contact with the home manager, the provider and local authority safeguarding team to ensure that they were kept informed of the progress and outcome of the investigation. Strategy meeting minutes dated 27 January 2016 were provided to CQC detailing

the steps the provider had taken to mitigate any further risks to people using the service.

CQC carried out an unannounced comprehensive inspection of Meadbank Care Home on 4 April 2016. During this inspection no concerns were noted in relation to the moving and handling of people using the service and the service was rated Good overall but Requires Improvement in the key question Safe as there were some concerns about the administration of prescribed medicines.

A further unannounced focused inspection was carried out at Meadbank Care Home on 2 September 2016 following the receipt of additional information from Detective Sergeant [redacted] Wandsworth CID in relation to his investigation into Mrs Elliott's death. During this inspection we found that staff were trained in how to safely transfer people and understood the moving and handling needs of the people they were supporting.

We note that you identified the 'matters of concern' in your Report as follows:

1. That information in relation to transferring residents has been removed from display next to the resident e.g. from above their beds or inside their rooms.
2. That the removal of such information has made it harder for busy staff to access such information.
3. That as such, some residents may be being inappropriately transferred and thus sustaining injuries that may cause to contribute to their deaths as in this case.
4. That all homes should display as appropriate such information.
5. That the CQC should advise all residential homes that they should come up with such a system and implement it forthwith.
6. That the CQC should inspect homes and confirm that such systems are in place.

CQC's response to the specific concerns you have raised above are taken in turn and set out below:

1. **That information in relation to transferring residents has been removed from display next to the resident**

We have reviewed all of the reports written following our inspections of Meadbank Care Home on 14 July 2011, 8 November 2012, 21 May 2013, 24 September 2013, 6 November 2014, 4 April 2016 and 2 September 2016 and spoken with the lead inspectors involved in these inspections. We cannot find any evidence that CQC at any time asked staff at Meadbank Care Home to

remove moving and handling guidelines for staff from display in people's bedrooms. However, it is possible that a member of an inspection team brought this to the attention of staff as a potential issue in relation to people's privacy and confidentiality. We have drawn that conclusion as Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014 states that the registered person is required to ensure the privacy of service users and Regulation 17 states that people's care records must be kept securely. Prior to this Regulation 17(1) and 20(2) or the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 may have been considered in relation to this issue. These regulations were in force from 1 April 2010 until 31 March 2015. Therefore it is possible that whilst assessing the provider in relation to these regulations that an inspector advised staff to consider the implications of displaying information in people's bedrooms. CQC would not systematically object to the display of moving and handling information in people's bedrooms but would expect that staff had considered people's consent to this and what was in their best interests.

2. **Removal of information has made it more difficult for staff to access this information.**

The registered persons within care homes are required to ensure that staff have access to the information they require to meet the individual needs of the people they support which includes their moving and handling needs. This includes care plans and risk assessments and any guidance for staff to support them to meet people's needs appropriately and safely. Whilst it is accepted that information should be easily accessible to enable staff to complete their roles effectively, consideration must be given to the views of the person or their representatives in relation to displaying information in people's bedrooms to ensure their consent is given for this. If people are unable to make this decision, a decision must be made in their best interests in line with the Mental Capacity Act 2005. The two inspections that took place of Meadbank Care Home following the death of Mrs Elliott found that staff were aware of the correct moving and handling practices to follow for the individuals they supported and the content of people's care plans and risk assessments.

3. **Some residents may be being inappropriately transferred and thus sustaining injuries that may cause to contribute to their deaths as in this case.**

Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 require registered persons to provide care in a safe way for service users which includes assessing risks to health and safety and doing all that is reasonably practicable to mitigate such risks. It is not acceptable for staff to transfer people without reviewing the information available in people's care

plans and risk assessments to ensure that this is completed safely. It is expected that staff who are working with people have access to these records in order to guide them in the appropriate moving and handling techniques to transfer people safely and this is assessed as part of our inspection methodology.

4. **That all homes should display as appropriate such information.**

CQC has the statutory objective of performing its functions for the general purpose of encouraging the improvement of health and social care services. This is achieved by monitoring and inspecting services to ensure that they are meeting the regulations. Providers develop ways of meeting the regulations that are individual to the service and meet people's individual needs. CQC as the regulator does not have the power to insist that provider's meet the regulations in a particular way. However, CQC does provide guidance for providers about how to meet the regulations on our website which can be found here: http://www.cqc.org.uk/content/guidance-providers. Also we can ensure as part of our inspections that staff have access to all of the information that they require to meet people's individual needs appropriately and safely and take action where this is not the case. Care services find different ways of ensuring that care staff have access to the information they need to provide people with safe and appropriate care. For example, some services ensure that staff receive protected time to read and understand care plans and risk assessments and others keep care plan folders in people's bedrooms so that staff can access these easily for each individual.

5. **CQC should advise all residential homes that they should come up with such a system and implement it forthwith**

During the inspection process the inspection team will assess the performance of the provider against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As part of this process inspectors will assess whether or not providers are providing safe care and treatment under Regulation 12. This will include the assessment and management of risks associated with moving and handling. As stated above CQC does not have the powers to insist on how providers meet the regulations and therefore could not compel providers to develop and implement systems for displaying moving and handling information. However, CQC will assess the effectiveness of the systems providers have to assess, monitor and mitigate the risks relating to the health, safety and welfare of people using services and will take action against providers who fail to keep people safe from avoidable harm.

6. **That the CQC should inspect homes and confirm that such systems are in place.**

At all comprehensive inspections the inspection team will assess whether the provider is meeting legal requirements under Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure that people are receiving safe care and treatment. This will include assessing staff understanding of people's individual needs and access to information about people's needs as detailed in their care plans and any associated risk assessments. CQC will take action in accordance with its enforcement policy where providers are failing to provide safe care and treatment which includes the failure to operate safe moving and handling procedures.

If you have any further questions or concerns, please do not hesitate to contact us on the above number.

Yours sincerely

[redacted]
Head of Inspection (Adult Social Care) South east

(On behalf of [redacted]
Head of Inspection (Adult Social Care) London)