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03/01/2020

Care Quality Commission
Our Reference: MRR1-8002398689

Dear HM Senior Coroner

Prevention of future death report following inquest into the death of Mr Sidney Clarence BAKER

Thank you for sending CQC a copy of the prevention of future death report issued following the inquest touching on the death of Mr Sidney Baker.

As you are aware the CQC local inspection team were not in attendance at the Inquest. To respond to the points you have raised in your report, we have reviewed your report, the information we held and have completed an inspection of the service in response.

This response relates specifically to the points raised in your report.

1. There were no contemporaneous documents that dieticians or falls team referral had been made by the care home personnel in question.

A comprehensive inspection of Barley Brook was carried out on the 8 and 9 January 2020. As part of the inspection, we looked at people deemed at risk of malnutrition, or who had suffered unplanned weight loss and those at risk of falls. We noted appropriate referrals had been made to dieticians and the falls team as necessary. It was noted some referrals made had not been necessary, but had been completed as a precautionary measure, so professionals could make a determination about actions required, rather than the home. For example, despite unplanned weight loss, one person was rated as 'low' risk on the Malnutrition Universal Scoring Tool (MUST) and their BMI indicated they were obese,

however a referral had been made. This had been declined by the dietician for the aforementioned reasons.

Based on the evidence noted during the inspection, processes were now in place and being followed to make timely referrals to professional as required.

2. There were concerns entries contained in Mr Baker's care plan were incorrect, including vital information contained on his weight monitoring sheet. Furthermore, the general quality of record keeping was poor.

As part of the inspection we reviewed the electronic care records of six people, all of whom had nutritional needs. We found people's care plans and assessments contained varying amounts of out of date, contradictory or incomplete information. Overall, people's needs had been captured, however care plans had not been clearly written, out of date information had not been removed timely, which meant information provided was contradictory. For example, one care plan stated a person ate a well balanced diet, had three meals a day, with pudding after lunch and tea, however also stated they had a very poor appetite.

Documentation did indicate how often people required to be weighed, based on their MUST score and risk assessment and this guidance had been followed. Where any issues had been noted, action had been taken, including referrals to dieticians.

We also identified issues with contemporaneous records relating to people's personal care needs. Based on the records available, it was not possible to confirm people's hair, nail and oral care needs had been met consistently, as these sections of the monitoring form had not been initialled by staff as completed.

Audits and quality monitoring processes completed within the home and at provider level had failed to identify the record keeping concerns we noted.

3. I request you undertake a review to ensure staff receive the appropriate training on the issues identified above.

As part of the inspection, we looked at staff training and support. A new training provider had been sourced and face to face training sessions were being arranged for all staff, to ensure they had the necessary knowledge and skills to carry out their roles safely and effectively. However, this had only recently been introduced which meant a large number of staff's training was out of date. Overall training compliance within the home was at 67%.

In accordance with CQC's regulatory remit, we will be highlighting three possible breaches of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014 to the provider. These potential breaches relate to issues identified with record keeping, staff training and support and the providers quality monitoring processes.

We will also be highlighting three possible breaches of the CQC Registration Regulations 2009. These potential breaches relate to failure(s) to submit notifications of incidents to the CQC without delay, in line with the above Regulations. The CQC will investigate these incidents and consider whether it is appropriate to take any enforcement action in relation to them.

We will carry out a further comprehensive inspection within 12 months, to ensure action has been taken and the provider is no longer in breach. Should this not be the case, we will consider further regulatory action.

Finally, our records show we were not notified of this death by the registered provider, as was legally required. This failure to report has been raised with the provider and we will consider whether criminal enforcement action is appropriate.

Should you require any further information then please do not hesitate to get in touch.

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Please include the reference number MRR1-8002398689.

Yours sincerely

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