Care Quality Commission

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Alison Mutch OBE
HM Senior Coroner
HM Coroner Manchester South
Coroner's Court
1 Mount Tabor Street
Stockport
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7 February 2020

Care Quality Commission
Our Reference: MRR1-8119778830

Dear HM Senior Coroner

Prevention of future death report following inquest into the death of Mr Arnold Fletcher Ward

Thank you for the prevention of future deaths (Regulation 28) report issued following the Inquest touching on the sad death of Mr. Arnold Fletcher Ward.

We note the legal requirement upon Fernlea Care Home and the Care Quality Commission to respond to your report within 56 days.

The registered providers of Fernlea Care Home are Olea Care Limited.

The provider location registered with CQC is located at 20 Torkington Road, Hazel Grove, Stockport, SK7 4RQ. The provider is registered for the following regulated activities:

Accommodation for persons who require nursing or personal care
Treatment of disease, disorder or injury

The role of the CQC & Inspection methodology

The role of the Care Quality Commission (CQC) as an independent regulator is to register health and adult social care service providers in England and to inspect whether or not the fundamental standards are being met.

Our current regulatory approach involves inspectors considering five key questions. They ask if services are Safe; Effective; Caring; Responsive; and Well Led. Inspectors use a series of key lines of enquiry (KLOEs) and prompts to seek and corroborate evidence and reassurance of how the provider performs against characteristics of ratings and how risks to people are identified, assessed and mitigated. Sources of evidence for the KLOEs can be found on our website along with our KLOEs and characteristics of ratings.

The regulatory framework includes providers being required to meet fundamental standards of care, standards below which care must never fall. We provide guidance to providers on how they can meet these standards (Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

Fernlea Care Home was inspected by CQC on 13 May 2019 and the comprehensive inspection report was published on 5 June 2019. The provider was rated Good overall across all our five domains; Safe, Effective, Caring, Responsive and Well Led.

Since the last inspection in May 2019 CQC had not received any information of serious concern in relation to this care home and the next comprehensive inspection was scheduled for December 2021. At the time of the inspection CQC was not aware of the circumstances of Mr Ward's case or subsequent death.

This response relates to the concerns expressed in your report that:

- Within the home the forms used did not capture the deterioration of the pressure ulcer or require detailed monitoring/use of photographs to track its progress. This meant that the significant and steep deterioration was not recognised and escalated at an early opportunity to the Tissue Viability nursing team for expert wound management input. As a result the type of wound dressings Mr Ward required were not utilised/available.

- It had been captured in the notes that there had been a referral to the Tissue Viability Nursing team in October 2018. There was no system in the home to chase up the team after a number of weeks had elapsed and there had been no response. The inquest heard that even in non-urgent cases the Tissue Viability Nursing team would contact a home requesting support in at least 10 days and more quickly in an urgent case.

The matters of concerns which arose from the preventing future deaths report were reviewed by CQC and a decision was made to undertake an unannounced, focused inspection of the Fernlea Care Home. This was because the concerns indicated that the registered provider may have been/may still be in breach of the following fundamental standards:

Regulation 12 (1) Care and treatment must be provided in a safe way for service users
Regulation 17 (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part (Part 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

The inspection commenced on the 27 January 2020. The inspection team consisted of an inspection manager and a lead inspector. The inspection was focused on two specific key questions; Is the service effective? and Is the service Well Led? Within the context of each domain our inspection team focused on the specific areas of concern raised in the report. We particularly looked at people's pressure ulcer management and management oversight of the home.

In addition, the registered provider had not submitted a statutory notification to us in respect of Mr Ward's pressure ulcer, as required under Regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009. Failure to notify is a statutory offence and we looked at whether there were other incidents that had occurred where the registered provider had failed to notify us. We will consider further enforcement action regarding this matter in due course.

Initial findings from the inspection have been fed back informally to the registered manager. Whilst the inspection team could see that some measures had been put in place to mitigate future risks to people using the service, we were not satisfied at this stage that the systems were sufficiently robust. The inspection further highlighted some additional lines of enquiry and following further management reviews on 28 January and 4 February 2020 a decision was made to extend our initial focussed inspection into a full comprehensive inspection. On completion of the inspection we will review the evidence and if we identify breaches in the regulations we will take appropriate and proportionate action in line with our enforcement policy.

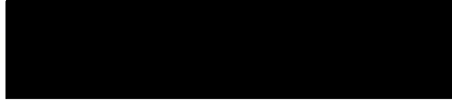
The inspection report will be published in due course and we are happy to provide a copy of the report to HM Coroner.

Finally, CQC proposes to make further enquiries as to the circumstances of Mr Ward's treatment prior to his death. As you are aware from 1st April 2015 the Commission has lead responsibility for investigating and where appropriate prosecuting breaches of fundamental care standards contained within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This includes

a failure to provide safe care or treatment resulting in avoidable harm or a significant risk of exposure to avoidable harm.

If you have any further questions or require further information please do not hesitate to contact us quoting the reference number MRR1-8119778830

Yours sincerely



Head of Inspection
Adult Social Care North West.