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Alison Mutch OBE
HM Senior Coroner
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[redacted]

4 June 2021

[redacted]

Dear HM Senior Coroner Alison Mutch OBE

Prevention of future death report following inquest into the death of Ruth Jones

Thank you for sending us a copy of the prevention of future death report (Regulation 28) issued following the sad death of Ruth Jones. Our condolences are with the family and friends of Mrs Jones.

We note the legal requirement upon the Care Quality Commission to respond to your report within 56 days, by 08 April 2021.

The role of the CQC & Inspection methodology

The CQC was established on 01 April 2009 by the Health and Social Care Act 2008 ('the Act'). The CQC is an independent regulator of healthcare, adult social care, hospital and community trusts and primary care services in England.

From 01 April 2015, the CQC has had the 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 ("the 2014 Regulations")

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, corroborate evidence and obtain reassurance of how the provider performs against characteristics of ratings. Furthermore, Inspectors obtain information as to how risks to people are identified, assessed and mitigated. Sources of evidence for the KLOEs can be found on our website along with the 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. These standards are contained in Regulations 4 to 20A of the 2014 Regulations.

Regulatory History

Meridian Healthcare Limited was registered to provide regulated activity at The Beeches on 17 November 2011.

Prior to registering a provider, the CQC registration team carry out relevant checks and interviews to assess the provider's suitability to be admitted onto the register. In order to continue assessing the provider's compliance with the Regulations, and the Act, inspections are undertaken.

CQC's last comprehensive inspection of The Beeches (published 3 March 2018) the service was rated as Good and there were no breaches of regulation. The Beeches had been rated Good at its previous inspection (published 08 October 2015).

You can find a copy of both of the above-mentioned reports on our website at https://www.cqc.org.uk/location/1-123208300

Relevant Background

Mrs Jones was admitted to The Beeches on 16 April 2018. The Beeches is a location registered with CQC at Yew Trees Lane, Dukinfield, Tameside, SK16 5BJ. The registered provider in operation of The Beeches at the time of Mrs Jones' death was Meridian Healthcare Limited. The provider is registered for the regulated activity: Accommodation for persons who require nursing or personal care. There are conditions on the registration for this location, namely the registered provider must not provide nursing care under accommodation for persons who require nursing or personal care at The Beeches; and the registered provider must only accommodate a maximum of 32 service users at The Beeches. The registered manager at the time was [redacted] who has been registered as the registered manager of The Beeches since 1 October 2010.

Statutory notification in relation to the death of Mrs Jones.

On the 23 June 2020, The Beeches submitted a Statutory Notification in relation to CQC in relation to the fall experienced by Mrs Jones on 17 June 2020, in accordance with Regulation 18 Care Quality Commission (Registration) Regulations 2009 ("the 2009 Regulations"). This notification detailed that Mrs Jones had sustained a fractured left hip. Having reviewed this notification we were satisfied with the measures The Beeches had put in place to mitigate risk of falls for Mrs Jones as much as possible and the action that had been taken subsequent to the fall.

On the 17 June 2020 Mrs Jones had become unwell and medical advice was sought from Digital Health. A diagnosis of suspected Covid-19 was made, and Mrs Jones was subsequently supported to isolate in her bedroom, in line with government guidance at that time. Mrs Jones was barrier nursed in her bedroom with the support of one to one staffing due to her presentation although she was not funded for this level of support. At approximately 4:30pm the staff member stepped out of the bedroom. They returned in response to the nurse call alert mat sounding and found Mrs Jones on the floor next to her chair. Following checks by senior staff, Mrs Jones later began to display discomfort and emergency medical assistance was called. Paramedics attended to Mrs Jones at The Beeches at approximately 7pm that evening and she was transferred by ambulance to Tameside General Hospital. Mrs Jones sadly passed away in the early hours of 21 June 2020.

We note the cause of death to be:
1a) Bronchopneumonia
II) Frailty, Dementia, Hypertension, Fractured Neck of Femur

Matters of concern for CQC

Upon receipt of the concerns raises as part of the Regulation 28 report issued to CQC by the coroner an unannounced targeted inspection of The Beeches was undertaken. This was completed to ensure that the circumstances of Mrs Jones death did not raise any ongoing risk to people currently living at the home.

The inspection commenced on 25 February 2021. The inspection team consisted of one inspector. The inspection was focused on one key question; Is the service Safe? Within the Safe domain the inspection targeted the Key Line of Enquiry: How are risks to people assessed and their safety monitored and managed, so they are supported to stay safe and their freedom is respected?

We focused on the specific areas raised in the Regulation 28 report. We looked at the assessment, monitoring, management of falls and arrangements for people requiring transfer to hospital for assessment and health care interventions.

We also looked at infection prevention and control (IPC) as part of a thematic inspection

methodology CQC is undertaking as a result of the response to the Covid-19 pandemic. This was reported under the key line of enquiry; Preventing and controlling infection.

We found the service had suitable processes in place to assess people's individual risk and addressed a wide variety of factors when considering what measures could be put in place to mitigate risk where possible whilst respecting an individual's preferences and choices. Where accidents and incidents had occurred, these were investigated to understand how it happened. Action was taken to reduce future risk and share learning across provider services. Hospital passports, which contained information about an individual's support needs, risk and medications were in place. These passports would be sent with service users attending hospital as part of the 'red bag scheme' the service participated in.

CQC understands that the 'red bag scheme' is a national initiative designed to support care homes, ambulance services and the local hospital meet the requirements of NICE guideline NG27: Transition between inpatient hospital setting and community or care homes.

The specific matters of concern raised by the coroner in the Regulation 28 report issues to CQC are:

1) ***The inquest heard that Mrs Jones was frail and at risk of falls. The home had a falls risk plan in place that was based around her being observed during the day in communal areas. The home was not staffed to provide one to one observations for residents required to self-isolate. As a result, when Covid 19 was suspected by the GP, and the home were directed to isolate her she could not be observed by staff as would generally be the case in the day. The home took some steps with sensors to ensure they were aware if she stood up whilst in her room but could not provide continuous observation. It was unclear how homes were being advised to safely manage residents at risk of falls where isolation was required. The home were unaware of any guidance that they should follow to manage the risk.***

In accordance with CQC's regulatory remit, we highlight breaches of the Regulations to a provider and where appropriate ask them what they are going to do to make improvements. We do not tell them what they should do. That is for the provider and/or registered manager (both being registered persons for CQC purposes) to decide.

CQC does not publish detailed standards and expectations about specific conditions. To do so would duplicate the work of more appropriate expert sources (for example the National Institute for Health and Care Excellence "NICE" and the Social Care Institute for Excellence "SCIE"). We expect registered persons to keep up to date with, take on board and implement good practice standards provided by relevant authoritative organisations.

NICE provide a variety of guidance regarding best practice for the management of falls in care homes. This includes Assessment and prevention of falls in older people

https://www.nice.org.uk/guidance/cg161/evidence/falls-full-guidance-190033741; falls in older people https://www.nice.org.uk/guidance/qs86/resources/falls-in-older-people-pdf-2098911933637. We are not aware of any specific guidance in relation to falls prevention for people isolating due to Covid-19.

At the time of Mrs Jones fall on 17th June 2020 there was Government guidance in place regarding the admission and care of residents in a care home during COVID-19 which was being followed by staff at The Beeches. Government guidance included https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/957296/Care_homes_guidance_updated.pdf and a variety of guidance in relation to COVID-19: how to work safely in care homes https://www.gov.uk/government/publications/covid-19-how-to-work-safely-in-care-homes.

The responsibility lies with the provider to ensure they have suitable processes to assess and provide appropriate support to people they support with regulated activity.

We have reviewed Mrs Jones' care records, and in this case, we believe that the service had taken all reasonable steps to mitigate the risk of falls for Mrs Jones. There were care plans in place to manage the risk of falls for Mrs Jones and these were relevant whether she was in communal areas or in her bedroom. Reference to times when Mrs. Jones was unwell were made and indicated that staff should make additional checks of Mrs Jones' welfare at those times. In our view, the registered manager had assessed Mrs Jones on an individual basis and despite her not being funded for one to one care had assessed risk and put measures in place to support Mrs Jones whilst she was unwell.

2) ***When Mrs Jones had to go to hospital she was sent alone and her family could not go with her due to Covid 19 restrictions. The inquest heard that Mrs Jones was frail and vulnerable. The inquest was told that the unsupported presentation/assessment of vulnerable, frail and elderly patients such as Mrs Jones presented significant problems to clinicians in terms of effective communication and understanding their health baseline to support appropriate and timely clinical decision making***.

NICE guidance includes Moving between hospital and home, including care homes. https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/moving-between-hospital-and-home-including-care-homes.

The Beeches participated in the red bag scheme. This is a national scheme that assists care home residents admitted to hospital to be discharged quicker. The bags contain key paperwork (hospital passport), medication and personal items like glasses, slippers and dentures. The hospital passport contained relevant information about the individual's current needs, a brief medical history, as well as important contact details and other relevant information about a person's preferences. These are handed to ambulance

crews by carers and travel with patients to hospital where they are then handed to the doctor. This process is designed to ease the transfer of people between care homes and hospitals and should have alleviated the concerns described during the inquest into the death of Mrs. Jones. The Beeches confirmed that the red bag scheme which included the hospital passport was used that day as part of the transfer of Mrs. Jones to the hospital.

Whilst this does not appear to indicate any required actions by Tameside and Glossop Integrated Care NHS Foundation Trust ("the Trust"), we have reviewed this regulation 28 report in conjunction with CQC colleagues from the acute hospitals directorate to enable CQC to provide a holistic response. We are aware that the Trust has a digital health service that is in use within all care homes in Tameside and Glossop to aid communication between the acute hospital, care homes and GPs. This service enables care home staff to readily exchange information with the acute trust and share health data for individual care home residents.

In order to ensure that that this risk is minimised to the lowest possible level and to ensure service users are not placed at risk at The Beeches, we are continually monitoring the service and liaising with the local authority to review any ongoing risks and feedback.

In summary, the requirement is placed on registered persons to ensure that they are delivering care in a safe and effective way and doing all that is practicable to mitigate any risks. CQC will continue to review through inspection the systems and processes being operated by those services it regulates. CQC will challenge and, if appropriate, take enforcement action against a registered person where it finds that care is being provided in an unsafe way.

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

Yours sincerely,

Interim Head of Inspection North West – Adult Social Care
Care Quality Commission