Care Quality Commission

HSCA Further Information
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Coroner's Office and Court
71 Northgate
Wakefield
WF1 3BS

For the attention of Ms Sarah Connor – Assistant Coroner

15 September 2021

Dear Madam,

Report to Prevent Future Deaths: Touching on the inquest into the death of Mr. John Dickinson.

I write further to the prevention of future death report issued following the inquest looking into the death of Mr. John Dickinson, who sadly died on 9th August 2020 after a period of care at Sunnyside Nursing Home.

Prior to submitting this response, I can confirm that the Care Quality Commission (CQC) has contacted the registered provider that operates Sunnyside Nursing Home, Bluebell Care Services Limited, to request written confirmation and evidence of the action they have taken to date following this death and any additional action they intend to take in response to the prevention of future death report.

We have now received this information and we are assured with the actions taken by the registered provider to address the specific concerns found during the inquest.

The provider is no longer providing care under the Community Care Bed contract which required the use of standardised paperwork that differed from the one usually used by the provider. The provider has indicated they have also reviewed the quality of their own documentation and care records. In relation to food records, in addition to improved documentation, staff have also received additional training. The provider has also indicated they have held individual and group staff meetings where the importance of quality care records were addressed, including advice from healthcare professionals.

The provider has showed a willingness to learn lessons from the investigation into Mr Dickinson's death and implement changes that will improve the safety of residents living at Sunnyside Nursing home.

As indicated in our previous letter to the HM Coroner on 10 November 2020, CQC gathered further information from the provider and the local safeguarding team in relation to the concerns surrounding Mr Dickinson's death.

It may be helpful for us to set out the result from previous inspections in respect of this Provider and Sunnyside Nursing Home. In May 2017 we inspected the service and rated it "Good" overall, rating the service "Good" in all areas i.e. safe, caring, effective, responsive and well led.

A further comprehensive inspection of the service was completed on the 12th and 18th of December 2019, with the report published on the 4th of February 2020. Again, the overall rating following this inspection was 'Good' overall and good in all areas.

We have since visited the home again on the 20 August 2020, to complete an inspection focused on the safety of the Infection Control policies and procedures carried out at the home and we did not find any concerns. For further information about our inspection's findings, please read the full reports here: https://www.cqc.org.uk/location/1-138395988/reports or the most recent one attached to this letter.

We believe it is important to note that the failures you describe in your matters of concern were not failures that had previously been ascribed to this service during our previous inspections. At the time of this gentleman's sad death, nursing homes and care homes generally were under huge pressure due to the Covid 19 pandemic. During the first 6 months of the Covid pandemic (and beyond) the focus at such places of care was very much on infection protection control, to try and stop the spread of the virus to keep vulnerable service users protected and safe. There was a focus on maintaining staffing levels in order to care for service users during lockdown, which raised previously unprecedented practical challenges for providers of care in this sector. This does not necessarily mean that sub-standard care was provided to service users during this period. However it is possible and indeed probable as Mr Dickinson's case highlights, there were failures in the day to day recording of the care provided to service users, which may not necessarily reflect the quality of care they actually received at that time.

In line with CQC's regulatory responsibilities, we continue to monitor statutory notifications and enquiries related with this service. Having considered the evidence and information available in this case, we have made the decision not to commence a formal Registered Provider investigation into Mr Dickinson's death. Whilst we acknowledge there were some apparent failures in the recording of care,

these appear to be individual in nature, and most likely committed by individuals who lie outside of the scope of the CQC's enforcement powers.

If you have any further queries, or require additional information in respect of this matter, please do not hesitate to contact the inspector for Sunnyside Nursing Home directly, their email address is [redacted] or alternatively you can contact the Inspection Manager [redacted]

Yours sincerely

[redacted]
Head of inspection Adult Social Care