Department of Health & Social Care

From Helen Whately MP
Minister of State for Care

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Your Ref: 312488
Our Ref: PFD-1219459

Ms Alison Patricia Mutch
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17 June 2020

Thank you for your letter of 24 April 2020 about the death of Mary Brady. I am replying as Minister with responsibility for adult social care.

Firstly, I would like to say how saddened I was to read of the circumstances of Mrs Brady's death and I extend my sincere condolences to her family and loved ones on their loss. It is important that we take the learnings from Mrs Brady's death so that people continue to receive the highest quality, safe care.

The matters of concern in your report are that there was a failure to dispose of Personal Protective Equipment (PPE) (in this case gloves) appropriately; that the contents of open wastebaskets can pose a choking hazard; and, that Mrs Brady's care plan had not been updated to reflect her care needs.

You issued your report to the Care Quality Commission (CQC) and Departmental officials have made enquiries with the CQC on the regulatory activity in relation to this incident. I am therefore aware that following a review of the circumstances of Mrs Brady's death; information provided by the registered provider and the action it has taken; and the findings of a CQC inspection conducted in February 2019, the CQC is satisfied that sufficient action has been taken to reduce further risks within the Balmoral Care Home and that there was insufficient evidence that a breach of the Regulations[1] had occurred. The CQC's response to your report provides further detail on its considerations in relation to this case.

I am advised that this will be reviewed at the next inspection, which as the Home is now registered to a new provider, is scheduled for April 2021, unless the CQC determines an earlier inspection is necessary. CQC will continue to monitor the service.

[1] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It is for the CQC as the independent regulator of all health and adult social care providers to monitor, inspect and rate services and the CQC has a range of powers it can take against providers when the quality and safety of services falls below the fundamental standards set out in Regulations.

Registered providers and managers of services are expected to ensure they are delivering care safely and doing all they can to mitigate risks through the conduct of local risk assessments (including for example, assessing environmental risks such as those associated with open wastebaskets). Providers are expected to plan care in line with good practice standards, such as guidance issued by the National Institute for Health and Care Excellence (NICE), and relevant professional and regulatory bodies.

There is guidance on how care settings should manage the use of Personal Protective Equipment (PPE). The NICE clinical guideline, *Healthcare-associated infections: preventions and control in primary and community care* (CG139[2]), recommends that everyone involved in providing care should be trained in the use of PPE, and that care settings should ensure that healthcare waste is disposed of in accordance with current national legislation and local policies.

NICE has published a social care quick guide titled, *Helping to prevent infection; A quick guide for managers and staff in care homes*[3], which is based on the NICE guideline CG139 and the NICE quality standard *Infection prevention and control* (QS61[4]). The quick guide includes a section on PPE that discusses the use of items such as gloves and aprons and says to "*Dispose of all used items correctly*".

In relation to ensuring care plans are updated and reflect a person's care needs, guidance to support the implementation of the Care Act 2014[5] states that keeping plans under review is an essential element of the planning process. The Act specifies that plans must be kept under review generally.

Without a system of regular review, plans could become quickly out of date meaning that people are not obtaining the care and support required to meet their needs. Therefore, local authorities should establish systems that allow the proportionate monitoring of both care and support plans to ensure that needs are continuing to be met. There are several routes to reviewing a care and support or support plan including:

- A planned review (the date for which was set with the individual during care and support or support planning, or through general monitoring);

- An unplanned review (which results from a change in needs or circumstance that the local authority becomes aware of, e.g. a fall or hospital admission); and,

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[2] https://www.nice.org.uk/guidance/cg139

[3] https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/helping-to-prevent-infection

[4] https://www.nice.org.uk/guidance/qs61

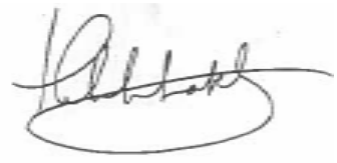
[5] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

- A requested review (where the person with the care and support or support plan, or their carer, family member, advocate or other interested party makes a request that a review is conducted. This may also be as the result of a change in needs or circumstances).

It is the expectation that authorities should conduct a review of the plan at least once every 12 months, although a light touch review should be considered six to eight weeks after agreement and sign-off of the plan and personal budget, to ensure that the arrangements are accurate and there are no initial issues. This light-touch review should also be considered after revision of an existing plan to ensure that the new plan is working as intended.

We expect all staff to have received the relevant training. It would be very challenging to cover all eventualities in a care worker's training. However, staff are trained to work in line with best practice, risk management, policies and procedures.
The Dementia Training Standards Framework[6] sets out the competencies expected of staff across three tiers of training. This includes a focus on person-centred care, and awareness of the different types of dementia, associated symptoms, and the importance of recognising a person with dementia as a unique individual. In this case, I am advised that CQC is satisfied that appropriate steps have been taken by the Balmoral Care Home to ensure that staff recognise the risks from choking and document them appropriately.

I hope this response is helpful. Thank you for bringing these concerns to my attention.



HELEN WHATELY

[6] https://www.hee.nhs.uk/our-work/dementia-awareness/core-skills