TRAFFORD
COUNCIL

Private & Confidential

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F.A.O: Alison Mutch
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

26th November 2020

Dear Ms. Mutch,

Re: Christina Rosemary Nield

I write in response to your enquiry sent to us on 2nd October 2020 regarding Christine Rosemary Nield.

You specifically asked us as the Local Authority and CCG to identify actions in respect of the following statements:

1) **During the course of the inquest evidence was heard that gloves were in open and easily accessible locations throughout the home including in rooms and the kitchen area. The inquest was told that this is standard practice in care settings for people with learning disabilities even where residents do not have the insight into what items can safely be placed in their mouths.**

   We would like to assure you that we have provided extensive guidance to our providers of the safe usage and disposal of Personal Protective Equipment (PPE). Following the outcome of Miss Neild's inquest, we have reiterated this message in our daily updates to our providers.

   As part of our ongoing scrutiny over this matter we plan to conduct bi-annual audits with providers to ensure that the new guidance is being adhered to. We plan to monitor this using a specific audit tool and also to embed it into our annual quality review using a tool called an iTool which is specific to Trafford. Once we have evidence that the practice is embedded it will move to the standard review which is recorded within the iTool.

All adults who may be at risk of ingesting inedibles, are subject to individual risk assessments, which include their capacity to understand the associated risks. For adults who lack capacity to understand the decision in question, any actions taken to safeguard the person will be undertaken in their best interests and in accordance with Mental Capacity Act (2005).

As you are of course aware, the use of PPE is fundamental to ensure the health and safety of all of our residents during the pandemic and needs to be accessible at all times. We have consulted with our providers to see how we can pragmatically manage the safe storage of gloves in particular.

The general feedback is that where the individual risk assessment is indicative of a potential risk of ingesting inedibles, our providers assure us that they would manage these instances in a variety of ways dependent on individual need, including (but not exhaustively);

- Locked cabinets or key pad locked rooms
- Support Staff signing in/out low number of gloves to retain on their person
- Staff carrying hazardous waste bags as opposed to hazard bins in people's rooms to ensure safe & immediate disposal in accordance with infection control measures

2) **There had been an earlier incident when Christine Neild had put non-food items in her mouth. The carer (family member) did not escalate this and there was no risk assessment.**

We have re-iterated to our providers, the importance that where <u>any</u> identified/reported need (from any source) is to be incorporated into the person's care delivery plan and escalated to the Registered Manager of the service. This will ensure that a risk assessment can be completed (where appropriate to do so) and those providing the care are aware of the person's support needs and can record any observations through established recording and incident reporting mechanisms.

The Provider in this instance has completed a lessons learned which has been shared with their staff. This will be shared with our Provider Forum to ensure the learning from this tragic case is shared across the Borough.

3) **The inquest heard that in care settings such as this one for those with learning disabilities there was no regular use of sensors to alert night staff of a resident getting up and wandering. Staff relied on hearing a resident**

getting up despite this being difficult if they were delivering care to another resident.

Every adult with perceived care and support needs is assessed under the appropriate legal frameworks afforded to the respective statutory agency; to ensure that eligible assessed needs and outcomes are met. This holistic assessment includes; the person's views and wishes, relevant history, their family/friends or representative's views and of course their needs for care and support including any night-time associated needs. The needs assessment will also incorporate the person's mental capacity in relation to their care and residence.

The assessment and subsequent support plan enables the Care Provider to produce a person centred care delivery plan. This details how the person's care will be provided and is individual to the supported person.

Assistive technology is an area which has advanced significantly over recent years and in Trafford, we have a local offer to support our residents and providers which includes the provision of bed/door sensors.

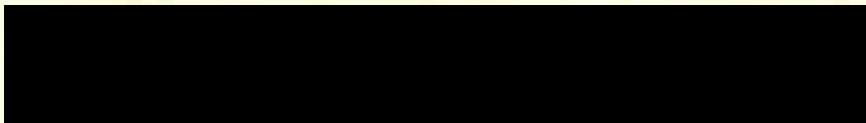
When meeting persons assessed needs, we must always ensure that we adhere to the appropriate legal frameworks. The prescriptive use of sensors could not be routinely provided as there may be implications pertaining to a person's right to liberty (Art 5 ECHR) without a bespoke assessment of need and capacity.

Despite the above, we would expect that any individual identified night time risk(s) are suitably risks assessed by the care provider with due consideration of assistive technology as a less restrictive option to mitigating the perceived risk.

All of our Care Providers have been reminded to consider the exploration of technological solutions and risk assessment for any supported person who is known to leave their room during the night.

We hope our response is satisfactory for the issues raised, please do not hesitate to contact us should you require further clarification;

Yours Sincerely,



Corporate Director of Adult Social Services
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1 Mount Tabor Street
Stockport
SK1 3AG

25 November 2020

Care Quality Commission (CQC)
Our Reference: [redacted]

Dear HM Senior Coroner

Prevention of future deaths report for Miss Christine Neild of Meade Close

Thank you for your Regulation 28, report to prevent future deaths issued following the inquest into the sad death of Miss Christine Neild on 21 September 2020.

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. The legislation that governs this function is The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of CQC's regulatory role, inspectors assess whether or not a provider is meeting the needs of people in a safe way. Inspectors make judgements from their findings as to whether a service has mitigated the risks posed to people, for example, physical risks arising from existing health conditions and environmental risks based on the surroundings in which they live. The CQC's website signposts the provider and registered manager to relevant guidance on how they can meet our regulations and other related regulations, including approach to risk.

As you are aware, a member of the CQC local inspection team attended the Inquest. This response relates specifically to the matters of concern raised in your report.

1. During the course of the inquest, evidence was heard that gloves were in open and easily accessible locations throughout the home including in rooms and the kitchen area. The inquest was told that this is standard practice in care settings for people with learning disabilities even where

residents do not have insight into what items can safely be placed in their mouths.

Risk assessment processes should include risks common to residents as well as risks specific to an individual, which may include the risk of a person falling out of bed, needing help with bathing or moving around safely. This assessment should include mitigating steps as to how to reduce the risk. Individual risk assessments may be integrated into 'care assessments' or 'support plans.' There is an expectation the provider considers the individual's needs and how these can be met whilst keeping the person safe.

Although gloves were in open and easily accessible locations at Meade Close this is not standard practice in care settings for people with learning disabilities, but often determined by the dependencies of the people living in the home. Gloves are worn by staff to protect people who receive support with personal care, have medicines administered or when they require more clinical interventions, such as suctioning or peg-gastrostomy care. Where people do not require that level of assistance staff may not need regular access to gloves and therefore the storage of these will differ accordingly.

A home's environmental risk assessment should consider the safe storage and use of personal protective equipment, including gloves. If gloves are to be worn by staff providing personal care, they should be easily accessible, as sterile as possible and stored appropriately to avoid cross contamination. A provider must consider all the above when risk assessing the storage of gloves, whilst ensuring that staff have rapid access to stock to manage the clinical needs of people with specific health conditions or to respond urgently in the event of an emergency, as was the case with Miss Neild.

2. There had been an earlier incident when Christine Neild had put non-food items in her mouth. The carer did not escalate this and there was no further risk assessment.

As part of our ongoing monitoring role, the inspector has been in contact with the registered manager to explore lessons learned and changes in practice to prevent this incident from happening to other people living at Meade Close. The provider has carried out an enhanced supervision with the staff member who failed to document and report the earlier incident, where Miss Neild placed non-food items in her mouth. The potential consequences of not reporting and documenting such incidents in a person's support plan have been discussed with the wider staff team. Staff will be refreshing their reporting and recording training and the provider is reviewing the induction programme delivered to new employees to incorporate these aspects.

We will check the provider's compliance with the regulations on our next inspection of the service using our key lines of enquiry and in accordance with CQC's

regulatory remit, highlight breaches of regulation to the provider and/or registered manager ('registered person') if warranted and ask them how they will make the necessary improvements. This service is due to be inspected within the next 12 months, in line with the current rating of Good. CQC however, have recently adopted a more risk-based approach to inspections and this date can change should we receive negative intelligence or have further concerns and judge that the service warrants more urgent scrutiny.

3. The inquest heard that in care settings such as this one for those with learning disabilities there was no regular use of sensors to alert night staff of a resident getting up and wandering. Staff relied on hearing a resident getting up despite this being difficult if they were delivering personal care to another resident.

The issue of using sensors to alert staff of residents getting up and moving around during the night should be addressed in individual care risk assessments. If it is known a person is inclined to do this and they are at risk of harm, control measures should be considered. For example, bed or door sensors or a sensor mat in their room. These are widely used in care home settings such as Meade Close.

From our observations of care planning documents and following discussions with the registered manager of the service Miss Neild did not require a sensor mat to be in place during the night. Support plans and corresponding risk assessments identified Miss Neild was fully mobile during the day and on occasions at night and was not at risk of harm. The inquest heard how Christine would sometimes seek staff out at night as she liked to do this. Placing an alert mat on the floor when someone is fully mobile can present as a trip hazard and becomes an additional risk. Whatever method a service chooses to help keep people safe it must be the least restrictive option, so people retain an element of control and independence in their lives.

Where CQC identifies that regulations are not being met, we use our enforcement powers to require improvements to be made. We continue to do this and will share key learning and practice points from the inquest into the death of Miss Christine Neild with inspectors and registered persons.

We hope that this response addresses your concerns. If this is not the case, please could you clarify any further details you require.

Care Quality Commission North (Central) Region