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HM Senior Coroner
Manchester South
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Care Quality Commission (CQC)
Our Reference: MRR1-6383963221

Dear HM Senior Coroner

Prevention of future deaths report following inquest into the death of Maria Katarina HRYNIW

Thank you for the prevention of future deaths report (Regulation 28) report issued following the Inquest touching on the sad death of Maria Katarina HRYNIW.

As you are aware the CQC local Inspection Team were not in attendance at the Inquest. To respond to the points, you have raised in your report, we have reviewed your report, the information we held and have completed an inspection at the service in response.

This response relates specifically to the points raised in your report.

The inquest heard evidence that:

1. Maria Katarina HRYNIW was peg fed. She was approaching the end of life but there was no assessment regarding the suitability of continued peg feeding in the community of the volume given to her. The inquest heard evidence from her family that she could not cope with the volume prescribed but continued to be given it. A community MDT was not held even when she was prescribed end of life medications. Maria Katrina HRYNIW lacked capacity to refuse PEG feeding and it continued as the home felt that ethically and legally they had to continue even as end of life care was in place. The inquest heard that some of the difficulties arose from an lack of understanding between the SALT team and care home about who would carry out assessment and who could make the key decisions regarding the use of peg feeding.

In accordance with CQC's regulatory remit, as with other regulators, 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 ('registered person') to decide. CQC does not publish detailed standards and expectations about specific conditions and meeting related needs. To do so would duplicate the work of more appropriate expert sources (for example NICE and SCIE) and impossible to keep safely up to date. It would also make our assessment framework far too long and detailed. We expect registered persons to keep up to date with, take on board and implement good practice standards provided by relevant authoritative organisations. For needs related to end of life care and the mental capacity act these include the Leadership alliance for the Care of Dying People, National Institute for Health and Care Excellence, General Medical Council, Social Care Institute for Excellence and the Mental Capacity Act 2005 (MCA) code of practice.

Our website does signpost registered persons to good practice guidance and standards to support them in meeting legal requirements.

We look at how people's end of life needs are met under Assessment Framework key question "Is the service Responsive?" The framework has 'Key Lines of Enquiry' (KLOEs) for inspectors to follow when answering the key questions. One of the KLOEs for 'Responsive' asks: How are people supported at the end of their life to have a comfortable, dignified and pain-free death? Inspectors explore how people, and their family, friends and other carers are involved in planning, managing and making decisions about their end of life care, and how people's pain and other symptoms are assessed and managed effectively, including having access to specialised support.

Consent to care and treatment is reviewed under Assessment Framework key question "Is the service Effective?" The framework has 'Key Lines of Enquiry' (KLOEs) for inspectors to follow when answering the key questions. One of the KLOEs for 'Effective' asks: When people lack capacity to make a decision, how do staff ensure that best interests decisions are made in accordance with legislation?

We inspected the nursing home on the 5 and 7 February 2019. Concerns raised in your report formed part of our inspection planning.

At the time of this inspection the nursing home was not supporting anyone at the end of their life. The nursing home had achieved beacon status with the Gold Standard Framework for end of life care, demonstrating that they are committed to providing good quality evidenced based care for people approaching the end of life. We spoke with the Registered Manager about the importance of

developing plans for end of life care when people are first admitted to the nursing home and the regular review of such plans.

We checked whether the nursing home was working within the principles of the Mental Capacity Act and found that assessments had been completed when people lacked capacity and best interest's meetings were held which included relevant professionals and significant others.

We are reviewing the facts and evidence in relation to Maria Katarina HRYNIW sad death at the nursing home to ascertain whether there is sufficient evidence to prove that a regulatory breach by the Registered Provider and/or Registered Manager has occurred.

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

Yours sincerely

[redacted]
Head of Inspection Adult Social Care (North Central)