HSCA Further Information
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Telephone: [redacted]
Fax: 03000 616171

Alison Mutch
HM Senior Coroner
1 Mount Tabor Street
Stockport
SK1 3AG

Via email: [redacted]

04 February 2021

Our Reference: [redacted]

Dear HM Senior Coroner Alison Mutch OBE,

Prevention of future death report following inquest into the death of Anthony Slack.

Thank you for sending the Care Quality Commission ('CQC') a copy of the prevention of future death report dated 01 December 2020 following the sad death of Anthony Slack.

We note the legal requirement upon the CQC was to respond to your report within 56 days, by the 26 January 2021 but you kindly agreed to extend this deadline to the 5 February 2021.

The registered provider of The Vicarage Residential Care Home at the time of Mr Slack's death was Clarkson House Residential Care Home Ltd (the 'Provider').

The Provider location (The Vicarage Residential Care Home) registered with CQC is located at 109 Audenshaw Road, Audenshaw, Manchester, M34 5NL. The Provider is registered for the regulated activity: Accommodation for persons who require nursing or personal care. There is a condition on the registration for this location, namely that the Provider must not provide nursing care under accommodation for persons who require nursing or personal care at The Vicarage Residential Care Home.

The role of the CQC & Inspection methodology

The role of the 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 and corroborate evidence and reassurance of how providers perform against characteristics of ratings and how risks to people are identified, assessed and mitigated. Sources of evidence for the KLOEs can be found on our website along with our KLOEs and characteristics of ratings. https://www.cqc.org.uk/guidance-providers/adult-social-care/key-lines-enquiry-adult-social-care-services .

The regulatory framework requires registered persons to meet fundamental standards of care, standards below which care must never fall. We provide guidance to providers on how they can meet these standards (Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014) (the 'Regulations'). https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulations-service-providers-managers .

Regulatory History

Clarkson House Residential Care Home Ltd were registered to carry on a regulated activity at The Vicarage Residential Care Home in January 2011.

Our last comprehensive inspection was October 2019. The service was rated as Requires Improvement. There was one breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred Care. The Provider had not ensured care was designed to meet service users' needs when providing social activities.

We found an infection prevention and control audit had been completed by infection prevention and control at Tameside in March 2019 and the home was found to be compliant in all areas and received an overall score of 94%. Staff had completed training in infection prevention and control and wore personal protective equipment (PPE), such as disposable aprons and gloves, when supporting people with personal care.

A new assessment had been developed to be used when admitting new residents. This included information about the support people needed and how those needs were to be met. It included people's personal, social and medical histories. This would help to ensure people were appropriately placed and the home could provide people with the support they needed. There was a system for monitoring falls. Records showed that appropriate treatment and support were sought in a timely manner. Care records were reviewed regularly and updated when people's needs changed.

This rating meant that under the inspection methodology we were using at the time, the service would be inspected by October 2021, but earlier if concerns were raised about the safety and welfare of people receiving the service.

Statutory Notification in relation to the Death of Mr. Slack

CQC received a statutory notification 'Death of a person using the service' from the Provider on 18 April 2020. This identified the cause of Mr Slack's death as due to suspected Covid 19 and that he had passed away in hospital. There were no details about the specific circumstances of Mr. Slack's death, therefore CQC had further discussions with the Provider who confirmed that Mr Slack had a fall and that following attendance by the ambulance service had been diagnosed with suspected Covid 19. The Provider had followed the advice of the ambulance service, and government advice at the time, and isolated Mr Slack in his bedroom. Mr Slack had been admitted to hospital on 11 April 2020 when his condition deteriorated. The Provider confirmed to CQC during this discussion that they had sufficient supplies of PPE and had access to and were following government guidance in relation to Covid 19.

In July 2020 as a result of information CQC received, unrelated to Mr Slacks death, we undertook a focussed inspection. This was a targeted inspection. The inspection was focused in one key question; Is the service safe? Within the safe domain our inspection focused on the specific areas of concern; about infection control, staff training and supervision, manual handling, building maintenance and management and reporting of safeguarding incidents.

During this inspection we found no breaches of Regulation.

Risks to people who used the service and staff, relating to infection prevention and control and specifically Covid 19, had been assessed and appropriate action taken. The Provider was promoting good infection control and hygiene practices.

PPE was used appropriately, and staff had received additional training, including handwashing and use of PPE. Staff confirmed they knew what PPE they should wear and that they could access stocks of PPE.

During this inspection, we found the Provider demonstrated they were aware of government guidance in relation to Covid 19 and had systems in place to ensure it was implemented in the home. The Provider's infection prevention and control policy and admissions policy were up to date.

The service did not receive a rating for this inspection as we did not look at all KLOE within the safe domain.

Prevention of Future Deaths Report

Following receipt of the concerns raised by the Coroner at the conclusion of the inquest into the death of Mr. Slack which resulted in the prevention of future deaths report. CQC undertook an unannounced, focused inspection of The Vicarage Residential Care Home. This was undertaken to ensure that the circumstances of Mr. Slack's death did not raise concerns about any ongoing risk to current service users

The inspection commenced on the 18 January 2021. The inspection team consisted of one Inspector. The inspection was focused in one key question; Is the service safe? Within the safe domain, our inspection focused on the specific areas of concern raised in the report. We looked at infection prevention and control (IPC). in accordance with the IPC thematic inspection methodology CQC developed as part of its response to the Covid 19 pandemic. This provides a framework to assess the systems and processes providers have in place to respond to the Covid 19 pandemic. It includes reviewing infection control policies and procedures, staff and Provider knowledge and implementation of government guidance, access to and use of personal protective equipment (PPE), staff and resident testing and safe admissions to care homes.

We also looked at risk management, falls management including post falls observations and protocols, accident and incident records, records of care provided and accessing and recording appropriate health support.

The specific matters of concerns raised by the Coroner, in the report are addressed below:

Matters of concern

1. **The documentation available at inquest from the home was limited in detail. As a result, it was difficult to understand what observations had been undertaken by the care home staff who were monitoring him.**

2. **The evidence given at the inquest was that the observations were of limited quality notwithstanding the diagnosis of Covid 19 and his vulnerability.**

At our inspections in October 2019 and July 2020 we found care records, including risk assessments and care plans were person centred and sufficiently detailed to guide staff in the support and care people needed. We also found that records of care and support provided were completed by staff.

CQC expects all services to have robust systems to ensure the quality of service and monitors that policies and procedures are being followed. We found there were a variety of checks and audits carried out in the home to ensure it was safe for the people living there. These included reviews of action taken following accidents and incidents, care record entries and observation records. These were overseen by the Provider to ensure any actions were completed.

At our inspection in January 2021, we found that improvements had been made to the systems and processes for post falls management. This included contacting Digital Health Team at set intervals post fall. This enabled Digital Health to support staff with observations; these were then recorded on the person's medical notes.

Digital Health have supplied monitoring equipment including blood pressure and pulse rate monitors to providers to enable this. A detailed protocol had been introduced that included guidance to staff on specific observations that should be taken and when they should be taken.

We saw that there was also an updated monitoring record for staff to complete when undertaking regular routine well-being checks. These required staff to indicate where the person was and what they were doing.

Staff we spoke with during the inspection were able to detail all aspects of the new system and what observations they were expected to complete if someone was ill or if they were undertaking routine well-being checks. The Provider had arranged training with Tameside Metropolitan Borough Council (TMBC) to improve daily record keeping.

3. **The inquest heard that after the home went into lockdown Covid 19 was found in residents within the home. At the inquest the home were unclear if staff had brought it into the home or if the admission of residents from the community who were not tested for Covid 19 before admission were the cause of it entering the home. There was no risk assessment in place relating to admission of new residents.**

Throughout the Covid 19 pandemic government guidance has been issued to providers on admissions to care homes and testing of staff. This did not at the time of Mr Slacks death include the requirement to test staff or residents before admission.

We have confirmed, through engagement conversations with the Provider in March, April and May 2020, and at our inspections in July 2020 and January 2021 that the Provider was aware of and was adhering to government guidance on the safe admission of people to care homes. This included isolation of new or Covid positive residents.

The Provider has also confirmed they are now undertaking the required regular resident and staff Covid 19 tests.

4. **Staff were unclear as to the PPE requirements as a result of the changes to the guidance that were occurring on a regular basis and it was unclear how changes were being shared with staff and implemented.**

We have confirmed, through engagement conversations with the Provider in March, April and May 2020, and at our inspections in July 2020 and January 2021 that the Provider was accessing the government guidance current at that time on use of PPE. On all of these occasions the Provider demonstrated that they were aware of current guidance and were ensuring staff were made aware of any changes via a staff Whats App group, emails and staff handovers. The Provider confirmed they were receiving updates from TMBC which included links to any changes in guidance to PPE use.

They confirmed they were also accessing COVID-19 related guidance for ASC providers on the CQC website.

During our inspections of July 2020 and January 2021, we observed staff wearing appropriate PPE. Staff had received additional training, including handwashing and use of PPE. Staff confirmed to CQC during both inspections, that they received updates from the Provider to inform them of any changes in guidance and knew what PPE they should wear and that they could access stocks of PPE.

5. **The inquest heard that the ambulance was delayed due to shortages of available ambulances. The inquest was told this was driven by a number of factors. This included staff absences due to the need to self-isolate awaiting testing and increased cleaning needs in relation to ambulances required by Covid 19. The inquest was told that at some points in the day and in some acute trusts, ambulance crews were being supported by on site cleaning crews. This meant quicker turnaround times and increased capacity. This was not consistent and not on a 24/7 basis. As a result, ambulances were struggling to reach vulnerable and unwell members of the public and transport them to an acute setting.**

As stated in the Regulation 28 Report, there are several contributing factors resulting in North West Ambulance Service (NWAS) delayed response times. NWAS have been transparent and open with the CQC to ensure we are aware of their performance and the factors that impact it.

We are continually monitoring the regional ambulance picture, through ongoing engagement, performance reports and internal meetings.

NWAS share with us their weekly HAS Report, Delayed admissions report and Weekly Snapshot (total turnaround for each Acute). We have monthly engagement meetings and attend national meetings.

NWAS have informed us they have adopted the AACE guidance to ensure appropriate changes have been made to ensure safety of staff and patients. For example, designated cleaning teams with appropriate training have been assigned to stations and hospital premises to support ambulance crews decontaminate vehicles. NWAS have placed decontamination areas outside hospitals, so that ambulances who have conveyed Covid 19 patients can be deep cleaned at the hospital site rather than go back to the stations. Vehicle cleaning is in line with PHE guidance, cleaning all contact areas after each patient is essential to ensuring both staff and patients are safe. Cleaning sites have been set up on hospital sites to make the deep clean process faster. This is so that ambulances can get back on the road quicker. This has reduced the risk of transmitting the virus but does impact on time.

In addition, we have been made aware of the impact on response times due to the delays caused by hand over at hospitals.

With regards to The Vicarage Residential Care Home, CQC expects registered persons to keep up to date with, take on board and implement government guidance. We have during the Covid 19 pandemic remained in regular contact with the Provider. This included engagement calls in March, April and May 2020. These were supportive calls to ensure that the Provider was aware of any updates to guidance and to signpost appropriate support if needed. CQC also published COVID-19 related guidance for ASC providers on the CQC website. From mid-March 2020 the Provider also received daily updates from TMBC which included updates on guidance, resources and support.

CQC is satisfied that appropriate steps have been taken to ensure that staff recognise risks from falls and illness and are aware what action they need to take, including ensuring appropriate medical support, what observations are expected, and how to document them appropriately. This is based on our previous knowledge of this location and how they have responded following the circumstances around Mr Slacks death.

CQC is of the opinion that the new processes that the service have adopted have addressed the known risks in this care home. CQC believe the actions taken by the Provider are what could reasonably be expected of them.

In order to ensure that this risk is minimised to the lowest possible level and to ensure service users are not placed at risk at The Vicarage Residential Care Home, we are continually monitoring the service and liaising with the Local Authority to review any ongoing risks and feedback.

In summary, CQC have reviewed systems in place at The Vicarage Residential Care Home and we are assured that the Provider has taken action to improve and further reduce risks within this care home. This will be reviewed at our next inspection of the service.

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

Yours sincerely,

Interim Head of Inspection North West – Adult Social Care