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4 February 2021

Our Reference: [REDACTED]

Dear HM Senior Coroner Alison Mutch OBE

Prevention of future death report following inquest into the death of Philip Taylor

Thank you for sending us a copy of the prevention of future death report issued following the sad death of Philip Taylor. Our condolences are with the family and friends of Mr Taylor.

We note the legal requirement upon the Care Quality Commission to respond to your report within 56 days, by 11 February 2021.

Mr Taylor was resident at Bamford Close, a location registered with CQC at Adswold Lane West, Cale Green, Stockport, SK3 8HT. The Registered Provider in operation of Bamford Close at the time of Mr Taylor's death was Borough Care Ltd. The Provider is registered for the regulated activity Accommodation for persons who require nursing or personal care. The registered manager at the time was Selina Taylor.

The role of the CQC & Inspection methodology

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.

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 the provider performs 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.

The regulatory framework includes providers being required to meet fundamental standards of care, standards below which care must never fall. These standards are contained in Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (“the 2014 Regulations”).

Background

On 18 June 2020, [REDACTED] from South Manchester Coroners’ Court contacted CQC to advise us of the unexpected death of Mr Philip Taylor at Stepping Hill Hospital on 6 January 2020 and inform us that this matter was being investigated. Due to a technical issue the provider had completed a statutory notification, but this had not been submitted and received by CQC. Following the information received on the 18 June 2020 a copy was immediately provided to the CQC inspector and this was submitted on 7 July 2020 by the registered manager at Bamford Close. The statutory notification stated that Mr Taylor began to show signs of declining health on the 2 January 2020 and a visit from the doctor was undertaken that day where advice was to encourage food and fluids. Mr Taylor’s health continued to decline the following day and the home contacted the doctor for further advice and subsequently called an ambulance. Mr Taylor was admitted to Stepping Hill Hospital on the 3 January 2020 and sadly passed away three days later on the 6 January 2020.

Further discussion was undertaken with the registered manager and CQC was assured that the provider and registered manager had taken appropriate action to support Mr Taylor as his health declined and seek medical advice as required.

Regulatory History

Borough Care Ltd were registered to carry on a regulated activity at Bamford Close on 18 January 2011. Mr Taylor was admitted to the care home on 4 April 2019. The last comprehensive inspection of the service was undertaken shortly after this in June 2019. The service was rated as good with no breaches of regulations being identified. Bamford Close is a residential care home and is registered to accommodate a maximum of 40 people. Bamford Close is registered for the regulated activity of ‘Accommodation for person who require nursing or personal care’ and a condition of their registration is that the register provider does not provide nursing care at this location.

At the time of Mr Taylor’s death there were 38 people living at Bamford Close and staffing levels were in line with the service dependency assessment. Staffing included care assistants, senior care assistants, the deputy manager and registered manager together with auxiliary staff including domestic and kitchen staff.

Bamford Close is not a location that offers nursing services and so retains no nursing staff.

Matters of concern for CQC

The staff in the care home were not medically qualified. The inquest heard that their ability to recognise and respond to an escalating risk of dehydration was limited. There was no national guidance to assist care home staff in understanding how to recognise; respond and escalate the risk of dehydration.

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 (both being Registered Persons for CQC purposes) to decide.

Registered Persons have a duty under Regulation 14 of the 2014 Regulations to ensure adequate nutrition and hydration for service users. The specific wording under Regulation 14(4)(a) refers to "receipt by a service user of suitable and nutritious food and hydration which is adequate to sustain life and good health".

CQC does not publish detailed standards and expectations about specific conditions. To do so would duplicate the work of more appropriate expert sources (for example NICE and SCIE - see below). We expect Registered Persons to keep up to date with, take on board and implement good practice standards provided by relevant authoritative organisations.

Information on the CQC website to signpost providers on meeting Regulation 14 is available. This includes links to a variety of best practice guidance including [Diet, nutrition and obesity \(National Institute for Health and Care Excellence\)](#) which is deemed relevant to all service providers. Other specific guidance to adult social care service included links to BAPEN (British Association for Parenteral & Enteral Nutrition): [BAPEN: Malnutrition universal screening tool](#); [Malnutrition Universal Screening Tool \(MUST\) explanatory booklet](#); Nutrition for specific groups (Royal College of Nursing); [Nutrition support in adults \(National Institute for Health and Care Excellence\)](#); Nutrition support in adults (NICE); [Nutritional care and older people \(Social Care Institute for Excellence, March 2009\)](#).

CQC also includes information on hydration in the [Frequently Asked Questions](#) section of its website. This section provides a general overview of some of the issues around hydration that Providers may need to consider when formulating and reviewing their policies and practices. In conjunction with the links to external sources provided (see above), CQC expects Providers to be able to find the information they require to support the hydration needs of their Service Users.

Other sources of guidance available in the public domain include: Getting it right every time (fundamentals of nursing care at the end of life) (Royal College of Nursing, 2015); SCIE guidance Nutrition for older people in care homes: Dignity in care videos; Dehydration in the elderly - British Nutrition Foundation; and Hydration and older people in the UK: Addressing the problem, understanding the solution (International longevity Centre UK, 2014). These provide examples of how to meet the nutritional and hydration needs of older adults. It should also be noted that research indicates that the signs and symptoms commonly used to detect dehydration are often ineffective in doing so in care home residents and that nursing and care staff focus should instead be on supporting older people to drink well (Effective hydration care in older people living in care homes; Nursing Times, 2019).

Like many care homes, Bamford Close supports care staff to complete the Care Certificate. There are 15 standards to the Care Certificate and standard 8 relates to fluid and nutrition. This standard covers the importance of good nutrition and hydration; the signs and symptoms of poor nutrition and hydration and how to promote adequate nutrition and hydration. Training records indicate that the majority of staff completed the care certificate or had other relevant qualification where this was pertinent to their role.

One of the KLOEs for answering 'Is this service Effective' asks: How are people supported to eat and drink enough to maintain a balanced diet? Inspectors explore the arrangements in place to manage people's nutritional and hydration needs, how people are involved in what they eat and drink and how risks to people with complex needs are managed. All KLOEs were reviewed following CQC's inspection methodology during the inspection of the service in June 2019 (report published 18 July 2019), at which Bamford Close was rated Good.

The death of Mr Taylor was reviewed as part of our regulatory duties, to assess whether there was any evidence of failings by a Registered Person that amounted to a breach of the Regulations. The conclusion of the initial review found that there was insufficient evidence of a breach of the Regulations. Mr Taylor had a nutrition and hydration care plan in place, along with a variety of other appropriate and relevant care plans. These were being reviewed on a monthly basis. An assessment of Mr Taylor's nutrition needs had also been recently reviewed in December 2019. Daily records were being completed and included food and fluid charts. The latter records both fluid offered and fluid taken by Mr Taylor, which would have assisted with auditing to ensure appropriate fluid levels were maintained. The meal chart is a similar mechanism for ensuring appropriate food intake.

The fluid charts indicate that overall support to maintain adequate fluids levels was good but there had a reduced intake at times, possibly due to declining health and Mr Taylor's diagnosed chest infection. This is particularly notable on 3 January 2020, the day Mr Taylor was admitted to hospital.

In order to ensure that that this risk is minimised to the lowest possible level and to ensure service users are not placed at risk at Bamford Close, we are continually monitoring the service and liaising with the local authority to review any ongoing risks and feedback.

In summary, the requirement is placed on Registered Persons to ensure that they are delivering care in a safe and effective way and doing all that is practicable to mitigate any risks. CQC will continue to review through its inspection processes the systems and processes being operated by those services it regulates and will challenge and, if appropriate, take enforcement action against a Registered Person where it finds that care is being provided in an unsafe way.

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

Yours sincerely,

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[Redacted Signature]

|
[Redacted Name]

Interim Head of Inspection North West – Adult Social Care
Care Quality Commission