HSCA Further Information
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

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

Via email: coroners.office@stockport.gov.uk

4th June 2020

Our Reference: MRR1-8843638527
Your reference: 312488

Dear HM Senior Coroner Alison Mutch OBE,

Prevention of future death report following inquest into the death of Mary Brady

Thank you for sending CQC a copy of the prevention of future death report issued following the sad death of Mary Brady.

We note the legal requirement upon the Care Quality Commission to respond to your report within 56 days, by the 19th June 2020.

The registered providers of Balmoral Care Home at the time of Mrs Brady's death were Mr [redacted] and Mrs [redacted] Since then a new provider, Cartwright Care Balmoral Management Limited has been registered to carry on the home.

The provider location registered with CQC is located at 29 Old Road, Mottram, Hyde, Cheshire SK14 6LW. The provider is registered for the regulated activity: Accommodation for persons who require nursing or personal care

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. 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).

Background

On 11 March 2019 the police (GMP) contacted CQC to advise us of the unexpected death of Mary Brady at Balmoral Care Home on 10 March 2019 and to inform us that a safeguarding meeting had been held and they were investigating this matter. We received a statutory notification from the registered provider on 11 March 2020. This stated that Ms Brady was found unconscious on the evening of 10 March 2019 and that when the paramedics attended, they found she had ingested a plastic glove.

Further information was requested from the registered provider including the service's PPE / Glove disposal procedure and any risk assessments in place at time of incident and details of whether any of those had been amended in light of the incident. We also requested the training matrix for all staff including first aid and CPR, names of the staff on duty, the staff rota covering the weekend 10 and 11 March 2019 and a copy of the action plan completed for Tameside council following the incident.

During a review of the information held about this incident it was noted that the service was inspected shortly before the incident and rated good. The process for disposal of gloves was in place and staff confirmed they were trained and understood the process. Staff had also confirmed this in statements to GMP. The presence of open waste baskets could not, in themselves, be attributed as a causal factor in Mrs Brady's death, nor staff failures to escalate previous risk behaviour such as other incidents where professionals had failed to safely dispose of clinical waste, or previous incidents where Mrs Brady had been found with non-food items in her mouth. The incorrect disposal of gloves allowed Mrs Brady to have access to, and subsequently ingest these gloves; this was a primary factor in Mrs Brady's death. However, CQC were of the opinion that the registered persons had taken reasonable steps to ensure the safe disposal of gloves. We have reviewed the action plan developed by Balmoral Care Home and local authority and are satisfied that enough action has been taken in response to reduce further risks within this care home. This will be reviewed at our next inspection of the service.

Regulatory History

Mr [redacted] and Mrs [redacted] were registered to carry on a regulated activity at Balmoral Care Home in February 2011. Mrs Brady was admitted to the care home on 26 February 2019 and just prior to that on 12 and 14 February 2019 we had carried out a comprehensive inspection of the service. The service was rated as good with no breaches of regulations being identified.

As noted earlier, the provider for this care home has changed since the inquest and Cartwright Care Balmoral Management Limited are now the registered provider and were registered with the CQC on 02/04/2020. This means that under our current inspection methodology the service, as a newly registered service, would be inspected by April 2021, but earlier if concerns were raised about the safety and welfare of people receiving the service.

Matters of concern

1. **The home at the time of Mrs Brady's death, in common with many similar establishments had open waste paper baskets in the communal areas. Residents with dementia were left unsupervised in these areas and there was always a risk that they might access material from these waste baskets. In this case the gloves should not have been in the bin at all but there were other items in there which could have presented a choking hazard. The home had since removed all open waste baskets from communal areas to avoid the risk. The inquest was told that similar baskets were common in care homes nationally.**

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. To do so would duplicate the work of more appropriate expert sources (for example NICE and SCIE). We expect registered persons to keep up to date with, take on board and implement good practice standards provided by relevant authoritative organisations. We are not currently aware of any good practice guidance in relation to the use of open waste baskets relevant to this type of setting.

Our regulatory duties in this case would be under regulation 12 Safe care and treatment 2 (e) ensuring that the equipment used by the service provider is safe to use for its intended purpose and is used in a safe way of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One of the KLOEs for answering 'Is this service Safe' asks: How are risks to people assessed, and their safety monitored and managed, so they are supported to stay safe and their freedom respected? Inspectors explore the arrangements in place to manage

risk appropriately and examine how people, their family, and other carers are involved in planning, managing and making decisions about any risks they might take. Furthermore, risk management policies are reviewed to look at how these minimise restrictions on people's freedom, choice and control, for people who lack mental capacity. All KLOEs were reviewed following CQC's inspection methodology during the inspection of the service in February 2019.

The death of Mrs Brady 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 this review found that there was insufficient evidence of a breach of the Regulations. The CQC view was that the presence of open waste baskets could not in themselves be causally linked to the death of Mrs Brady and that Mrs Brady's death was the result of individual staff error (failure to dispose of clinical waste appropriately) rather than a failure by a registered person.

Furthermore, CQC is aware that the action plan developed with Tameside local authority has led to the removal of all open waste bins within Balmoral Care Home and has reduced any ongoing risk in this area. Whilst risk of people living with dementia ingesting non food items can never be fully mitigated, CQC believe the actions taken by the provider are what could reasonably be expected of them.

To ensure that this risk is minimised to the lowest possible level, this will be reviewed by CQC at the next inspection which under our current inspection methodology would be by April 2021 at the latest.

2. **The gloves were clinical waste and had been disposed of other than in the clinical waste bin in the secure area. The inquest heard that there had been previous instances of used gloves being found in the waste baskets. However, the issue had not been escalated to senior managers and no steps had been taken to avoid the issue reoccurring.**

CQC expect all services to have robust systems to ensure the quality of service and monitor that policies and procedures are being followed. At the last inspection of Balmoral Care Home in 2019 it was found there were a variety of safety checks and audits carried out in the home to ensure it was safe for the people living there. These were overseen by the registered manager to ensure any actions were completed. We have reviewed all the notes from this inspection and the inspection team had not been made aware at that time that there were incidents when staff were not following procedures or that staff failed to highlight risk and concerns when these were identified.

CQC is aware that multiple sets of disposable gloves and clinical waste was found in the waste basket at the time of Mrs Brady's death but it is not clear what was actually present prior to the death and what was placed in the basket when the incident was responded to. We are also aware that there had been previous instances where gloves were found in the waste basket as part of the information Balmoral Care Home shared within safeguarding meetings following Mrs Brady's death. The information from the

home stated that there were two separate incidents whereby health professionals had disposed of their clinical gloves incorrectly. 1) by a paramedic who had left their gloves for the home care to dispose of and 2) again by a paramedic who left clinical gloves after treating a resident in their bedroom. External health care services will have their own policies and procedures for disposing of clinical waste, such as disposable gloves, when visiting community settings and care homes. It would be the visiting professional's responsibility to safely dispose of their own clinical waste.

It would be good practice for staff to discuss such incidents with the manager so these could be addressed at a senior level. There were clear policies for the disposal of gloves and all staff were aware of the correct procedure. Therefore, any failure to dispose of gloves appropriately (or escalate incidents where gloves had not been appropriately disposed of) does not seem to be attributable to failings of a registered person. The CQC understood that these previous incidents were dealt with as isolated incidents and were not considered to be a trend or ongoing risk presented by visiting external health care services.

It has not been possible to resolve the issue of where the gloves ingested by Mrs Brady on the 10th March 2019, came from. All care staff stated they were aware of the correct procedure for disposing of gloves and deny having used the waste basket to dispose of their gloves.

CQC are aware that the action plan developed with Tameside local authority has led to a new policy on the use of PPE and new system of checks for the use and disposal of PPE.

To ensure that this risk is minimised to the lowest possible level, this will be reviewed by CQC at the next inspection which under our current inspection methodology would be by April 2021 at the latest.

3. **Mrs Brady had been seen putting non-food items in her mouth by staff. These instances had not been appropriately documented and risk assessed. The level of risk she presented was not fully understood as a result and her care plan was not updated.**

Our regulatory duties in this case would be under regulation 12 Safe care and treatment 2 (a) and (b); assessing the risks to the health and safety of service users of receiving the care or treatment and doing all the is reasonably practicable to mitigate any such risk of the Health and Social Care Act (2008).

We look at how risk is managed under Assessment Framework key question "Is the service Safe?" The framework has 'Key Lines of Enquiry' (KLOEs) for inspectors to follow when answering the key questions. One of the KLOEs for 'Safe' asks: How are risks to people assessed, and their safety monitored and managed, so they are supported to stay safe and their freedom respected? Inspectors explore the arrangements in place to assess and manage risk appropriately and examine how

people, their family, and other carers are involved in planning, managing and making decisions about any risks they might take.

We look at how an individual's needs are managed 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 do people receive personalised care that is responsive to their needs. Inspectors the arrangements in place to develop care plans that are fully reflective of people's physical, mental, emotional and social needs.

Mrs Brady was admitted to Balmoral Care Home on the 26th February 2019 and 12 days later, on the 10th March 2019, was found unresponsive in the communal lounge.

Care plans are subject to continual review and assessment of individual's need and are ongoing. CQC would expect that care plans completed during the initial period of admission relating to Mrs Brady's care would be subject to continual review whilst staff developed a fuller understanding of Mrs Brady's needs and risks. It is good practice for care staff to escalate any unusual behaviours to senior staff so that this could be more fully assessed.

CQC is satisfied that the management of risk at this service, based on our inspections prior to Mrs Brady's admission, where broadly speaking, care plans and risk assessments were reviewed and deemed adequate. The CQC is not aware of any specific national good practice guidance to guide staff in this area and arrangements will vary across different providers of services. There is some anecdotal evidence that it is not uncommon for people living with dementia to place non-food items in their mouths. However, there is limited research in this area and dementia care training does not typically cover this unlike dysphagia training.

In Mrs Brady's case the escalation of unusual behaviours did not occur as individual care staff did not recognise the significance of this risk and saw this behaviour in isolation.

The CQC is satisfied that appropriate steps have been taken to ensure that staff recognise risks from choking and document them appropriately. This is based on our previous knowledge of this location, how they have responded to this incident and the input from Tameside Local Authority in developing an action plan.

CQC is aware of the action plan developed with Tameside local authority which has included 1) New handover sheets which clearly highlight risks for each resident and clarify staff members responsibilities during the shift; 2) daily communication meeting for domestic workings; 3) Reviews of daily/ weekly/monthly environment risk assessments. CQC is of the opinion that the new processes that the service have adopted have addressed the known risks in this care home.

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 Balmoral Care Home, we are continually monitoring the service and liaising with the local authority to review any ongoing risks and feedback. In addition, the action plan will be reviewed by CQC at the next inspection which under our current inspection methodology would be by April 2021 at the latest.

In summary the requirement is placed on providers and registered managers to ensure that they are delivering care in a safe 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 the registered person where it finds that care is being provided in an unsafe way.

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