HSCA Further Information
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[redacted]

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

[redacted]

04 April 2024

[redacted]

Dear HM Senior Coroner Alison Mutch OBE,

Prevention of future death report following inquest into the death of Susan Wendy Bracegirdle

Thank you for sending CQC a copy of the prevention of future death report issued following the sad death of Susan Wendy Bracegirdle.

We note the legal requirement upon the Care Quality Commission to respond to your report within 56 days, by the 29 March 2024 and would like to thank you again for agreeing to an extension for response until 12 April 2024.

The registered provider of Stable Steps Care Centre is Stable Steps LTD. They have been registered with CQC since 15 March 2021.

The provider's location, Stable Steps Care Centre is located at 47 Adswood Lane West Stockport Cheshire SK3 8HZ. The provider is registered for the regulated activity: Accommodation for persons who require nursing or personal care and Treatment of disease, disorder or injury.

The registered manager of Stable Steps Care Centre is [redacted] who has been registered in this role with CQC since 6 April 2021.

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 assess/inspect whether or not the fundamental standards are being met.

The regulatory approach used during the inspections of Stable Steps Care Centre considers five key questions. They ask if services are Safe; Effective; Caring; Responsive; and Well Led. Inspectors used 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.

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).

On 6 February 2024 Operations Network North went live with our new Single Assessment Framework. This approach will cover all sectors, service types and levels and the five key questions will stay central to this approach. However, the previous key lines of enquiry (KLOEs) and prompts have been replaced with new 'quality statements'. The quality ratings statements are described as 'we statements' as they have been written from a provider's perspective to help them understand what we expect of them. They draw on previous work developed with Think Local Act Personal (TLAP), National Voices and the Coalition for Collaborative Care on Making it Real. They set clear expectations of providers, based on people's experiences and the standards of care they expect. We have introduced six new evidence categories to organise information under the statements, which includes feedback from people, staff and leaders, processes and outcomes.

This approach will allow CQC to use a range of information to assess providers flexibly and frequently, collect evidence on an ongoing basis and update ratings at any time; tailor our assessment to different types of providers and services; score evidence to make our judgements more structured and consistent; use site visits and data and insight to gather evidence to assess quality and produce shorter and simpler reports, showing the most up-to-date assessment.

Background

We have reviewed all our records and cannot find that we received a statutory notification for serious injury to Mrs Bracegirdale in relation to the grade 3 pressure injury identified at the point it was identified in October 2022. We received a notification in relation to abuse or allegation of abuse on 20 January 2023 in relation to Mrs Bracegirdle. This was in relation to an incident on 12 December 2022 when Mrs Bracegirdle's dressing became displaced, and the pressure injury wound was found to have been infected. A statutory notification in relation Mrs Bracegirdle's death was submitted on 01 March 2023 where we were informed she had been suffering with a grade 2 pressure injury (although we are now aware this had in fact deteriorated to a grade 3 pressure injury in October 2022) managed by the district nursing team, the pressure injury was not healing and suddenly deteriorated. Treatment was provided at the care home at first with IV antibiotics. However, Mrs Bracegirdle failed to respond and was then admitted to hospital on 16 December 2022, and treated for seven weeks in hospital, where due to co-morbidities and poor health she was not able to fight the infection. We were advised the case was with the coroner's office, under investigation, with an inquest date 03 July 2023.

Regulatory History

Stable Steps Care Centre has been inspected by CQC on two occasions since it was registered with us. We first inspected Stable Steps Care Centre in 2022 and rated the service Requires Improvement overall and in the key question 'Is the service safe?', 'Is the service effective?'; 'Is the service responsive?' and 'Is the service well led?'; the key question 'Is the service caring?' was rated good. At that inspection we found breaches of regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which included; a breach of Regulation 9 (Person centred care) as people were not consistently having their needs met in a person centred way; a breach of Regulation 12 (Safe care and treatment) as systems of checks of the environment were not sufficiently robust to ensure shortfalls were addressed in a timely way and people who required their medicines to be administered in a specific way, either crushed or administered covertly, did not have records to demonstrate this had been fully assessed or detail for staff on how to administer these medicines safely; a breach of Regulation 17 (Good governance) as systems for oversight of the safety and quality of the service were not robust to ensure improvements were made and risk was mitigated as much as possible; and a breach of Regulation 19 (Fit and proper persons employed) as recruitment processes were not being completed in a sufficiently robust way to demonstrate that staff were safely recruited. Requirement notices were issued and the provider completed actions plans in response to the breaches identified.

The second inspection of Stable Steps Care Centre took place in June 2023. The overall rating and all key questions were rated Requires Improvement. Breaches of regulation were identified and requirement notices issued for; a breach of Regulation 17 (Good governance) as systems were not sufficient to ensure compliance with the requirements of regulation and assess, monitor and improve the quality of the service, and that accurate and contemporaneous records were maintained; a breach of Regulation 18 (Staffing) as staff were not sufficient and suitably deployed to ensure people received timely, appropriate and safe person-centred care; and a breach of Regulation 19 (Fit and proper persons employed) as robust recruitment processes were either not being followed or not being suitably recorded to ensure staff were safely and appropriately recruited. A breach of Regulation 9 (Person-centred care) was also found as people were not consistently receiving person centred care that met their needs and preferences or was in line with their assessed needs and a warning notice was served on the registered manager. The provider completed an action plan following that inspection to tell us how they were going to address the breaches of regulation.

CQC continue to monitor the service in line with our regulatory responsibilities and future inspections of Stable Steps Care Centre will be completed under the new single assessment framework.

Matters of concern

1. **The inquest heard evidence that because Mrs Bracegirdle was in a care home setting the District Nurses were responsible for management of her pressure ulcers. The care home was asked to ensure pressure relieving processes were followed. However, the District Nurses did not share care plans with the care team on the basis that they were digital documents and were care plans for the use of District Nurses. As a consequence, the care home management were not fully sighted, and joint care was more difficult to deliver increasing the risk of the pressure ulcers deteriorating**.

Following receipt of your Preventing Future Deaths report we contacted the district nursing team and requested the treatment records for Mrs Bracegirdle. Review of the records identified that whilst at most visits the district nurses advised the care staff regarding the importance of frequent repositioning, there appeared to be gaps in the records where any care or treatment advice, if given, was not documented. Nevertheless, CQC would expect Stable Steps Care Centre to have their own detailed care plan for Mrs

Bracegirdle for the maintenance of her skin integrity, based on current advice from the district nurses and good practice guidance.

We reviewed the care records for Mrs Bracegirdle from Stable Steps Care Centre and found that neither the care plan for skin integrity, nor the care plan for pressure ulcers had the required level of detail for care staff to follow. The first rapid review undertaken by the district nurse team leader on 28 October 2022 identified that there had been a lack of effective communication between the care provider and the district nursing team. One action arising out of the review was for the district nurses to discuss regularly with the care provider all residents under the care of the district nurses to jointly review and improve communication.

At our last inspection of Stable Steps Care Centre on 8 and 19 June 2023 we found that improvements were needed to ensure communication worked effectively within the home. Feedback from people living at the home and their families was mixed with some people feeling staff were responsive to their needs, whilst others gave examples of where they felt there had been delays in receiving treatment. Families also told us communication between healthcare services and the home could be difficult, staff were not always able to identify deterioration in people and that liaison and referrals with external services could be improved.

Under the new single assessment framework CQC will be able to consider the question of joint working in more detail, as we seek evidence that the registered provider works in line with Quality Statements such as “We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services” and “We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.” We will ensure that these two Quality Statements are included in the next assessment of the service and will follow up on what actions have been taken to date to address the shortfalls in communication that we found at the last inspection.

2. **There was no communication strategy in place as a consequence of an approach that did not promote team /joint working. The inquest heard that as a consequence the family were unsighted on the condition of Mrs Bracegirdle until shortly before her admission to hospital. This meant that the family could not support the work to reduce the risk of the pressure ulcers deteriorating further and were not able to be a proactive about the**

care she was receiving increasing the risk of her pressure ulcers deteriorating.

We would expect, as parties to general reviews of care whilst at the home, a person's family to be involved and informed, with the consent of the individual, regarding their care, treatment and progress. We note that the registered manager in her statement, advised that she had apologised to the family for the failure to keep them informed regarding Mrs Bracegirdle's pressure ulcers and that she had committed to investigating this shortfall. We will follow up on the outcome of the investigation to seek assurance that any actions arising from the investigation will mitigate further risks that families are not kept informed where appropriate within acceptable timeframes.

3. **The GP was asked to provide input. Due to a lack of information sharing the GP who dealt with Mrs Bracegirdle does not seem to have appreciated the extent of the issue and as a consequence there was no face-to-face examination and antibiotics were not started.**

On review of the medical case summary for Mrs Bracegirdle it is clear that she was seen by the GP on a number of occasions from August 2022 onwards (16 August 2022, 18 September 2022, 28 September 2022, 12 October 2022, 14 October 2022, 26 October 2022 in person and on 11 December 2022 by video link). The GP noted on 14 October 2022 that Mrs Bracegirdle had been referred to the Tissue Viability Nurse (TVN), the specialist in the management of wounds. As such it would be reasonable for the GP to expect that treatment of the pressure ulcer would be led by the TVN with the GP only being advised if the treatment was becoming ineffective.

The district nursing notes dated 09 December 2022 refer to the wound having a strong malodour and heavy grey yellow exudate. It was recorded "follow up with the GP as I suspect the wound is infected". However, it is not clear whether the district nurses or care home staff had the responsibility for doing this. The second rapid review undertaken by the district nurse team leader on 16 December 2022 identified that there was no evidence that the concerns were escalated to the GP and a referral to the GP was only made on 13 December 2022, at which time antibiotics were commenced for a wound infection. Action arising from the rapid review was to discuss with the district nursing team the importance of following up any concerns or actions with the GP and not relying on the care staff to ensure this is done. We will follow up what actions have been taken to date to ensure clear lines of responsibility have been established and are working well for the benefit of service users.

4. **There had been a safeguarding review undertaken. However key people involved in her care had not provided input to the review which meant there was no clear holistic assessment of what lessons could be learnt to reduce the risk of deaths from pressure ulcers in the future. It was unclear why such an approach had been taken.**

Until recently CQC had no remit in respect of local authorities and the way in which they conducted or carried out safeguarding reviews. From 1 April 2023 CQC has new responsibilities under part 1 of the Care Act to assess how local authorities are meeting their duties. A key component of the assessment framework will look at how local authorities ensure safety within the system, which will consider the effectiveness of Section 42 enquiries and reviews.

5. **An earlier internal review by the District Nursing team when Mrs Bracegirdle's pressure ulcer became a category 3 was not shared or discussed with the family and they were unsighted on the issue**.

As we stated at point 2, we would expect, as parties to general reviews of care whilst at the home, a person's family to be involved and informed, with the consent of the individual, regarding their care, treatment and progress. It was clear from the registered manager's witness statement that the family were unaware that Mrs Bracegirdle had a pressure ulcer until 12 December 2022, when [redacted] informed them of the fact and that a safeguarding referral had been made.

However, in respect of advising the family about the district nursing team's internal review it appears that [redacted] herself was unaware that the safeguarding team had already held a strategy meeting in October 2022 and it was unclear if she was aware of the internal review that had taken place. As the coordinator of all health and care interventions carried out in the home, the registered manager and senior staff at the home have the responsibility of sharing relevant important information and we would expect systems to be in place to ensure this happens. The registered manager advised the family that she would investigate why this did not happen and we will follow up on the outcome to seek assurance that any actions arising from the investigation will mitigate further risks that families are not kept informed where appropriate within acceptable timeframes.

6. **The Tissue Viability team had been asked by the District Nurses for input. This was provided remotely via access to photos taken by the District Nursing Team. Whilst it was clear that remote review could be effective it was not in this case because the review was based on an older image and**

an updated image showing a deteriorating picture in relation to the pressure ulcers was not uploaded. This was as a result of lack of joint working and effective communication. The impact was that what would have been helpful expert input from the TVN was not provided to a deteriorating picture.

Although the TVN reviewed Mrs Bracegirdle's treatment plan remotely the treatment plan discussed and agreed with the district nurses on site did not change between 14 December 2022 and 30 December 2022 when she was in hospital, with antimicrobial dressings and IV fluids being administered. It is therefore unclear to what degree, if any the treatment plan would have altered, had the tissue viability nurse seen an updated photo, although we acknowledge this would have been helpful.

Following the two rapid reviews held by the district nursing team, the proposed action in both cases was for a local review – required to address the care and service delivery issues identified and to share learning from the incident. We will follow this matter up with Stockport NHS Foundation Trust at future engagement meetings to ensure that appropriate reflection has taken place and learning from this incident disseminated.

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 Stable Steps Care Centre, we are continually monitoring the service and liaising with the Integrated Care Board to review any ongoing risks and feedback.

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 our assessment process the systems and processes being operated by those providers it regulates and will challenge and if appropriate take enforcement action against the registered person(s) where it finds that care is being provided in an unsafe way.

Should you require any further information then please do not hesitate to contact us.

Yours sincerely,

[redacted]

[redacted]

Deputy Director of Operations

Network North, CQC