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HSCA Further Information
[redacted]

Alison Mutch OBE
[redacted]

Via email: [redacted]

22 July 2024

Our Reference: **CAS-381929-X7C5W2**
Your reference: **32900408**

Dear HM Senior Coroner Alison Mutch OBE,

Prevention of future death report following inquest into the death of Frederick Martin Gerard Boyd

Thank you for sending CQC a copy of the prevention of future death report issued following the sad death of Frederick Martin Gerard Boyd.

We note the legal requirement upon the Care Quality Commission to respond to your report within 56 days, by the 27 June 2024 and would like to thank you again for agreeing to an extension for response until 26 July 2024.
The registered provider of The Lakes Care Centre is The Lakes Care Centre Limited. They have been registered with CQC as a service provider since 25 August 2023.

The provider's location, The Lakes Care Centre is located [redacted]. At the time of Mr Boyd's death, the provider was registered for the regulated activities: 'Accommodation for persons who require nursing or personal care' and 'Treatment of disease, disorder or injury'.

The Lakes Care Centre does not currently have a manager who is registered with CQC to oversee and manage the delivery of the regulated activities at this location, in line with the condition imposed on this provider's registration for this location, stating that they must

have a registered manager in post. The current home manager, [redacted] submitted applications to register with CQC on 25 February 2024 and 6 March 2024. These applications have been rejected by CQC's registration team as being incomplete and a new application has not yet been received or processed by CQC. The previous registered manager, [redacted], was registered with CQC between 25 August 2023 and 13 October 2023 to manage the regulated activities at The Lakes Care Centre under the current provider The Lakes Care Centre Limited.

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 set out in the Health and Social Care Act 2008, and amendments, are being met.

The regulatory approach used during previous inspections of The Lakes Care Centre considered five key questions. They asked if services were 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 performed against characteristics of ratings and how risks to service users were identified, assessed and mitigated.

The regulatory framework includes providers being required to meet fundamental standards of care; the 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 CQC's Operations Network in the North region went live with our new Single Assessment Framework. This approach covers all sectors, service types and levels and the five key questions remain central to this approach. However, the previous key lines of enquiry (KLOEs) and prompts have been replaced with new 'quality statements'. The quality 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; these are feedback from people, feedback from staff and leaders, feedback from partners, our observations, 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 in relation to Mr Boyd's death. Failure to provide statutory notifications in accordance with Regulation 16 of the Care Quality Commission (Registration) Regulations 2009 is a criminal offence and we have written to the registered provider to request an explanation for their failure to notify and will review their response and may take further action. Subsequently we have contacted the service to request Mr Boyd's care records so this case can be reviewed under our specific incident guidance.

Regulatory History

The Lakes Care Centre was registered with CQC under the current provider, The Lakes Care Centre Limited on 25 August 2023. Prior to this the service was managed by Blackcliffe Limited.

Under the previous provider, Blackcliffe Limited, there had been poor compliance with relevant regulations and CQC had taken numerous enforcement actions to drive improvement which had ultimately led to the service being rated 'Inadequate' overall and the provider going into administration. An inspection undertaken in February 2023 (published 13 April 2023) identified some improvements had been made to the service delivered. It was subsequently rated 'requires improvement' overall with conditions placed on the registration. This allowed the administrators to proceed with a sale of The Lakes Care Centre as a going concern. The Lakes Care Centre Limited commenced operating the home under a licence to manage agreement on 18 July 2023 and the sale of the home was completed on 22 September 2023.

The Lakes Care Centre has been in a multiagency concern (MAC) process led by Tameside MBC since 23 May 2022. This process brings together key stakeholders including commissioners, health services, CQC and the provider to oversee and support the provider and to share information both positive and negative about the service delivered and progress towards improvements in performance.

On the 22 April 2024 CQC began an assessment of The Lakes Care Centre which included on-site and off-site processes. The decision to assess was following several concerns being raised at a MAC meeting in relation to ongoing safeguarding concerns, particularly those in relation to people with nursing needs. As a result, CQC undertook an

assessment looking at all quality statements and evidence categories relating to the key questions ‘Is the service safe?’ ‘Is the service effective?’ and ‘Is the service well led?’ At the time the assessment commenced The Lakes Care Centre had stopped delivering the regulated activity of ‘Treatment of Disease, disorder and injury’ and all people with nursing needs had been transferred to alternative placements by 19 April 2024.

Matters of concern

1. The inquest heard evidence that there was no clear system or expectation regarding the quality of checks on a resident who exhibited signs of being unwell.

During our assessment of The Lakes Care Centre, inspectors spoke with people who used the service and their families. Families were happy and people all felt confident that staff would promptly seek support from other healthcare professionals when this was required. However, shortfalls in record keeping and systems of oversight meant that people were placed at the risk of avoidable harm. Staff were not consistently receiving sufficient training and support in their role. There were shortfalls in the training records and the systems in place for oversight were not effective to allow for easy identification of gaps in training. Not all staff had received regular supervision and there were no clear systems of oversight of supervision to ensure staff were suitably supported. We identified breaches of Regulation 12 (Safe care and treatment), Regulation 18 (Staffing) and Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On publication of the report of our assessment we will require the registered provider to provide an action plan with clear timescales for completion of each action identified and will review progress against this action plan in line with our processes.

2. The evidence before the inquest was that the documentation in relation to the key period was limited and that there appeared to be a limited understanding by staff of the level of detail required and that oversight of the quality of documentation by senior managers was limited.

During our assessment we identified areas for improvement in terms of care plans, risk assessments and staff understanding of using Person Centred Software (PCS), the electronic care planning and recording system used at The Lakes Care Centre. The registered provider was already aware of this and was arranging additional training. As stated in our response to Point 1 there were also areas for improvement in relation to governance and oversight identified during this assessment, that we will continue to monitor and assess on an ongoing basis.

3. The evidence before the inquest indicated that the system for escalation where a patient was unwell was unclear and not understood by staff.

Inspectors did not identify any issues in respect of systems for escalation and staff understanding of this during our assessment and on-site activity. Feedback from the digital health service, the local clinical assessment service covering all care homes in Tameside, was that it was generally being used appropriately. Partner agencies felt things were improving overall and were complimentary about the staff working for the service who it was felt generally knew service user's needs.

At the time of Mr Boyd's death, The Lakes Care Centre was operating as a nursing home, but the service has now ceased to deliver the regulated activity of 'Treatment for Disease, Disorder or Injury'. This means that any service user requiring a nursing intervention will be under the care of the district nurses, which CQC believes mitigates some risks to the residents of this service as the service users being cared for will generally not have such complex health conditions.

Since the provider has registered to manage the regulated activities at the location there have been a number of changes in the management team and structure of the service. There had been concerns about the service and the level and speed of improvement being made. Partner agencies raised concerns that information had not always been escalated effectively and statutory notifications which services are required to send to CQC were not always completed. As stated above, we have written to the registered provider regarding this matter and will review their response to determine appropriate action.

The provider was in the process of restructuring the management arrangements for the two open units when we carried out our recent assessment. Of the two open units, one specialised in providing purely residential care and the other specialised in residential dementia care. This process had not been completed and we will review the impacts of this decision when we next assess the service.

At the time of our visit there was no registered manager and although the home manager intended to register with the CQC, the application had not yet been successfully accepted. We will follow this up with the manager and seek to register them as soon as possible.

Yours sincerely,

[redacted]

[redacted]

Deputy Director of Operations

Network North, CQC

Regulation 28 – Report to Prevent Future Deaths

Ref: Mr Frederick Martin Gerard BOYD – 2nd May 2024

Response from The Lakes Care Centre

Narrative:

The Lakes Care Centre, at the time of the incident and when Mr Boyd was admitted and resided, was under the control and management of financial administrators. They were brought in by the failure of the previous owner to properly manage the home. The local authority and ICB were instrumental alongside CQC in bringing about this change.

This was an extremely challenging time for the employees and residents of The Lakes Care Centre. There had been no clear leadership, no organised and formal training, a denigration of the facilities within the centre, reliance on agency staff and topped 'off with' poor quality care and support to all its residents. A clear 'recipe' for problems.

Mr Boyd was admitted 21st April 2023. He was a resident under the nursing registration on [redacted].

On 6th July 2023 a group of investors agreed to purchase the home form the administrators. This group included [redacted] – Previous owner until 2020, [redacted] and one other. On 26th September 2023 we finally gained full managerial accountability of The Lakes Care Centre. All three of the main Leadership personnel have a full and successful history (spanning over 80 years combined) in delivering excellent quality care and support to vulnerable people.

From our records we know Mr Boyd passed away on 11th September 2023.

We note for the Regulation 28 Report that the cause of death has been listed as: Complications of long -term catheterisation contributed to by neglect. The medical cause of death was:-

1a) Peritonitis
1b) Bladder Perforation due to long-term urinary catheterisation
II) Paraplegia resulting from injuries sustained in a Road Traffic Collision (2012)

In section 4 CIRCUMSTANCES OF THE DEATH - there is a comment:
'There is no documentation to indicate that effective and regular checks were carried out during the night – 10th September – 11th September.

On reading the care notes (competed by both care staff and nursing staff whilst on shift and supporting residents) it does show that regular patient checks were carried out and his symptom management was routinely supported through the night. I have attached a copy of the notes and highlighted the key times when observation and support was delivered and offered. It shows the nurse administering his prescribed medications and also pain relief [redacted] after complaining of severe abdominal pain. He was continually observed during the night and these are recorded in his care notes. However, I accept that formal clinical observation (blood pressure, oxygen saturation and body temperature) was not recorded.

Given all of the above, I believe he was supported adequately during the night but this could have been recorded better.

In Section 5 – MATTERS OF CONCERN - it states in:

1. *'....there was no clear system or expectation regarding the quality of checks on a resident who exhibited signs of being unwell.'*

2. *'The evidence before the inquest was that the documentation in relation to the key period was limited and that there appeared to be a limited understanding by staff of the level of detail required and that the oversight of the quality of documentation by senior managers was limited.'*

3. *The evidence before the inquest indicated that the systems for escalation where a patient was unwell was unclear and not understood by staff.*

The Lakes Care Centre was under the management of the Administrators for some considerable time and during this time it appears that no formal training was undertaken for any employees and no formal team meetings, especially with the clinical team, were held either. The Manager brought in by the administrators failed to manage the service effectively and did not manage the interface between care and clinical needs. They left the service soon afterwards by mutual agreement.

The current leadership team, appointed a Clinical Lead in October 2024 to lead on all matters Clinical. Part of this new role was to liaise with the Manager on all matters Clinical and to ensure that all the correct protocols were in place. We hold weekly Leadership meetings and as part of this process the Clinical Lead would share progress and updates on current Clinical matters and progress on the required clinical protocols. Regularly we were assured that all things required were in place.

However, when we began to audit the clinical processes and the team, it became clear that not everything was as described. The training on such matters as 'Knowing when a resident is unwell' had not been undertaken and no clear guidance was in place for clinical employees.

Given this discovery and the fact that The Lakes Care Centre was having difficulty finding and retaining good nurses, we decided to de-register our Nursing Service. Therefore, we will never be in the position of not satisfactorily caring, clinically, for anyone again.

Our current Residential services, have clear protocols for knowing their residents 'well' status and how to identify if they are 'unwell', as well as how to escalate via local district nursing teams and Digital Health Care coordinators.

Please see link (https://www.tamesideandglossopicft.nhs.uk/services/digital-health-services - an initiative here in Tameside to assist providers in getting more effective support for residents at the time they need it).

To expand on what we have undertaken so far:

a) Started all training from 'scratch' to ensure all employees get the same level and undertraining of what is required in all care and health matters. This is via Team meetings, individual 1:1 sessions, E Learning and Face to Face training.
b) We are introducing (July 24) a new E Learning platform which will enable employees to access mandatory and developmental learning with associated policy and procedures attached as part of that learning. It will also provide much better visibility of employee learning progress and prompts employees and managers of the expectations in a timely manner to maximise attendance and outcomes.
c) We have reviewed all employee performance against Job Descriptions and observation of practice and moved decisively to re-configure our workforce with people who are committed and able to deliver the excellent care and support we are striving for. This meant in practice a new manager being appointed, new Nominated Individual (CQC) and new leadership structure with clear lines of accountability and reporting responsibility.
d) We have begun to nurture again our relationship with the local Infection Prevention Teams and Contract Monitoring Teams to 'move' forward on our performance on a day-to-day basis and improve the quality of care and support and outcomes for our residents.
e) Reduce our reliance on 'agency staff' to zero currently. This helps us be confident in our employees/workers skills and performance. In addition, we have more day-to-day confidence that our employees are following our Core Values in everyday practice.
f) Improve employee morale with clearer direction and support to get things right first time. Feedback from employees has been excellent since we took over and they are saying they feel more supported and valued as a team.
g) Improve resident and family feedback. From some initial surveys and face to face meetings, the feedback we are getting is that our service is welcoming, excellent and very caring. The facilities are described as outstanding and very homely.

Therefore, given all of the above, we hope this helps you understand the progressive steps we have made since this incident and how we understand the need for clear and effective care/support to ensure the safety and well being of all our residents in their time of need.

[redacted]

Response written by: [redacted]
Operations Director and Nominated individual (CQC)

On behalf of The lakes Care Centre Limited.