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

Via email: [redacted]

12 November 2024

Our Reference: [redacted]
Your reference: [redacted]

Dear HM Senior Coroner Alison Mutch OBE,

Prevention of future death report following inquest into the death of Mr James Astley

Thank you for sending Care Quality Commission (CQC) a copy of the prevention of future death report issued following the sad death of Mr Astley.

We note the legal requirement upon the CQC to respond to your report within 56 days, that being by 5 November 2024. Please accept our sincere apologies for the delay due to one of our staff being on sick leave from work.

The registered provider of Downshaw Lodge is Qualia Care Limited. Qualia Care Limited has been registered with CQC as a service provider since 11 November 2016.

The provider's location, Downshaw Lodge, is located in Downshaw Road, Ashton Under Lyne, OL7 9QL. At the time of Mr Astley's death, the provider was registered for the regulated activities of 'Accommodation for persons who require nursing or personal care' and 'Treatment of disease, disorder or injury'.

The role of the CQC & Inspection methodology

The role of CQC as an independent regulator is to register health and adult social care service providers in England and to assess whether or not the fundamental standards as set out in the Health and Social Care Act 2008, and amendments, are being met. CQC also have civil and criminal enforcement powers should providers be assessed to have breached the fundamental standards set.

The regulatory approach used during previous inspections of Downshaw Lodge considered five key questions. They asked if the service was 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 obtain 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 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; 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

CQC first became aware of the death of Mr Astley on 30 January 2024 when a statutory notification of death was submitted by the provider. This was assessed by an inspector at the time who sought further information due to the notification indicating that a safeguarding referral had been raised against the care home. The safeguarding investigation records were reviewed and although areas of learning were noted for the provider, CQC was assured that the necessary actions were already in progress. These actions included ensuring all people living at the home had up to date and relevant care plans as well as training for staff around the use of the digital health service in order to effectively escalate health concerns.

Downshaw Lodge has been under the multi-agency concerns (MAC) process since the provider Qualia Care Limited appointed an administrator on 18 October 2022. The last MAC meeting CQC attended in May 2024 raised no concerns about the care people were receiving. CQC was advised that work was planned to ensure all staff had completed the care certificate, there were plans in place to manage the challenge of recruiting staff to health and social care roles, to review and update care plans and that Downshaw Lodge were working well with local authority quality improvement and commissioning teams.

Regulatory History

At the time of Mr Astley's death there was no registered manager in post The previous registered manager had deregistered from the role on 12 June 2023. A manager registered with CQC as the registered manager of Downshaw Lodge on 5 June 2024 but has subsequently left this role although no application to deregister has currently been received.

The first inspection of Downshaw Lodge was completed in November 2018. The overall rating for the service was 'requires improvement' and the key questions 'Is the service safe?' and 'Is the service well led?' were found to require improvement, with the key questions 'Is the service effective?' 'Is the service caring?' and 'Is the service responsive?' all being rated good. At that time breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. The provider was found to be in breach of Regulation 12 (Safe care and treatment) due to shortfalls in the management of medicines and infection prevention and control, and Regulation 17 (Good governance), due to systems for audits and checks not being effective.

The next comprehensive inspection of Downshaw Lodge was commenced on 9 January 2020 and the service was rated good in all five key questions. Previous breaches of regulation found during the inspection of 2019 had been resolved.

CQC last visited the service to complete a targeted inspection looking at infection prevention and control on 17 February 2022 as part of the response to the Covid 19 pandemic. No concerns were identified at that time.

Matters of Concern

1. **The inquest heard evidence that Mr Astley was at significant risk due to poor nutrition and fluid intake. However, the MUST documentation was not correctly completed and the overall quality of fluid and nutrition charts was poor. As a consequence, he became increasingly frail and the risk to his overall wellbeing and physiological reserves continued.**

CQC were made aware of the sad death of Mr Astley in a notification submitted by the provider (via the home manager) on 30 January 2024. This notification informed CQC not only of Mr Astley's death but also of the safeguarding concerns raised by the family at the point Mr Astley was admitted to hospital, in relation to which a strategy meeting had been arranged for February 2024. CQC reviewed the minutes from the strategy meetings as part of the initial triage of this notification. This meeting was held on 22 February 2024 via teams. The strategy meeting focused on a number of areas including:

- the use or lack thereof of a hospital passport or red bag scheme when Mr Astley was admitted to hospital,
- the accuracy of care plans and risk assessments, with areas of shortfall being found in the medication care plan, choking risk assessment and nutritional risk assessment,
- lack of contact with external professionals as Mr Astley's condition declined, including the speech and language therapy team and dietitian,
- and failure to utilise the digital health systems.

The strategy meeting found that there was evidence of relevant referrals being made and followed up although this was impacted by the holiday period. The safeguarding investigation found evidence that weekly weights for Mr Astley were being completed and recorded in a weight folder, which up until the 5 December 2023 had been reasonably stable. Mr Astley's weight had deteriorated between the 5 December when it was recorded as 47.1kg and 1 January 2024 where it was recorded as being 43.9kg. The dietitian had been contacted on 22 December 2023 and confirmed they would review in 3-4 weeks. The strategy meeting also looked at concerns in relation to the calling of an ambulance. The finding was that a call came from the home on 3 January 2024 at 12:02 and an update was provided at 13.47 to inform that the GP was making a home visit. The safeguarding minutes noted 'GP had attended and re-assessed and initially stated that

he could be treated at home, however when the GP returned to the surgery, he recontacted the care home and instructed the nurse to recall an ambulance to take Mr Astley to hospital.' No evidence of a direct call from the GP was found.

Learning was identified for the home at the point of the strategy meetings including education sessions for staff in relation to the use of the digital health service in Tameside, the use of hospital passports and red bag scheme to aid the transfer of important information as people transfer between services and clinical meetings and reflective supervision with staff in relation to record keeping and care planning. The final action from the strategy meeting was that all covert medication, care plans, best interest and GP discussions would be reviewed by the home to ensure all paperwork was correct and documented. Since this strategy meeting was held the home continued to be engaged with a MAC process with monthly or bi-monthly meetings being held with key stakeholders including the local authority commissioning team, safeguarding team, the home manager and representatives from the provider. Records from these meetings indicate improvements have been made and the situation at Downshaw Lodge is positive.

Following the issuing of the Regulation 28 report to Downshaw Lodge, CQC have reviewed the response and learning from the provider and sought further assurances. The provider has shared their response to the Regulation 28 report which included action taken in regard to documentation, oversight, communication and training. We have reviewed example documentation shared by the provider as part of the assurance given including care records and systems for oversight and analysis. There are indications that the necessary processes for appropriate assessment and documentation are available for use.

Subsequent to the Regulation 28 preventing future death report CQC have commenced an assessment at Downshaw Lodge to ensure the required changes have been made, especially in regard to ensuring staff have received the training and support needed to complete accurate assessment of people's needs, take appropriate action and following care plans in line with people's needs to ensure all care needs are met, and maintain accurate and contemporaneous needs. This assessment was commenced on 16 October 2024. Once this has been completed a report will be published on the CQC website with our findings. This can be found on the link

https://www.cqc.org.uk/location/1-4019291170/reports

2. **Overall documentation at the home was limited and lacked detail**

CQC have reviewed Mr Astley's care plans and what daily records were available. There were a number of shortfalls regarding the levels of detail, frequency and accuracy of recording. CQC have reviewed 2 weeks of daily records in relation to Mr Astley eating and drinking for the period of December 2023. The service has been unable to locate other records relating to this time period, in particular we have not been able to review the daily records in relation to Mr Astley's hospital admission where the evidence is that there was a dramatic deterioration in Mr Astley's health and presentation. The records reviewed indicated that Mr Astley had been monitored regarding his eating and drinking and was supported and encouraged to eat and drink by staff throughout the day. Some documentation was not available for review as the provider was not able to locate these. The quality of the records varied, and it was not possible to determine to what extent Mr Astley's nutritional needs were met, although records indicate he was prescribed a supplement drink to increase his nutritional intake on a daily basis. Mr Astley appeared to have had a fluid target of 2000ml per day. It was unclear whether this was an appropriate target given Mr Astley's weight and frailty and subsequently was rarely achieved on the records reviewed. However, the fluids accepted were often in excess of 1200ml based on the records available for review. As noted above regarding the safeguarding strategy meeting, the provider had identified and accepted improvements were needed and implemented an action plan which has been reviewed at the MAC meetings led by the local authority.

When CQC receives information in relation to an incident of this kind, we consider what action we need to take; firstly in relation to whether the information received suggests that there may be ongoing risk which requires CQC to inspect a service and secondly whether the information received suggests criminal enforcement action should be considered. As noted earlier an inspection of the service has been commenced on the 16 October 2024 to review any matters in relation to ongoing risk and our findings will be published once the process has been concluded. CQC have also undertaken an initial assessment in respect of this death to determine whether criminal enforcement action should be considered. The assessment has involved reviewing information available regarding Mr Astley's care, including information from the inquest and information provided by the care home provider. At this time, the initial assessment has concluded that there is no evidence of a registered provider level failure and therefore the threshold at which criminal enforcement would be considered has not been met in this matter.

An inspection of Downshaw Lodge was commenced on 16 October 2024. As part of this inspection and assessment of the service, CQC will review documentation within the home to assess whether it is accurate, up to date and sufficiently detailed to ensure people's needs are met. Our finding will be published on the CQC website when the process is completed at **https://www.cqc.org.uk/location/1-4019291170/reports**

Yours sincerely,

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Deputy Director of Operations
Network North, CQC