Northamptonshire Safeguarding Adults Board

Safeguarding Adults Review

SAR 021

Executive Summary

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Introducing the Executive Summary

This Executive Summary provides an accessible version of the Safeguarding Adults Review (SAR) commissioned by Northamptonshire Safeguarding Adults Board (NSAB) regarding the care/treatment of residents of Temple Court Care Home, Albert Street, Kettering, Northamptonshire between January 2020 and May 2020. The SAR is a thematic review of the key issues and provides findings, suggests learning and recommendations to improve practice. Sadly, 19 residents of the care home died during the period under review, four of those deaths were recorded as attributable to Covid-19. The content of the overview report have been significantly enhanced by the involvement of some of the families who lost relatives during this time. At the start of the process there were two authors but one could not continue for reasons unconnected to the SAR. During the review learning was identified and a Learning Briefing has been developed to address this, which can be found on the NSAB website. For this reason, the identified learning is not duplicated within this Executive Summary.

1. Context and background

1.1 Temple Court Care Home ("the care home") was a nursing home for older people and those living with dementia. The care home was registered with the Care Quality Commission (CQC) to provide personal care for up to 54 people and was run by Amicura Limited under the umbrella of the Minster Care Group. From 27th February 2020 the care home was registered solely to Amicura Limited.

1.2 Whilst the period under review is January 2020 to May 2020, there was a need to understand the context in which the care home was operating, along with the quality and standard of its care to residents as reported on by the CQC following its inspection in May 2019.

1.3 In May 2019 the care home was inspected by the CQC receiving a rating of "requires improvement" and as a result of the inspection, it was required to complete action plans for the CQC and for both the CCG[1] (Clinical Commissioning Group) and the Local Authority (the then Northamptonshire County Council)[2]. The care home was subject to further quality assurance visits by both in relation to the progress of the required improvements and in response to some whistleblowing and safeguarding concerns.

1.4 There are some key national dates and circumstances that feed directly into the situation within the care home. The first two confirmed cases of Covid-19 were reported in the United Kingdon on 31st January 2020 and in February 2020 there was a national requirement in England for the discharge of all medically fit patients from local hospitals to free up bedspace. The beginning of the national lockdown in England commenced on 23rd March 2020 and the establishment of local emergency procedures under the Civil Contingencies Act 2004 and Local Resilience forums[3] were commenced during early March 2020 to manage the response to the pandemic.

1.5 On 11th March 2020, the care home closed to all non-essential visitors, two weeks prior to the announcement of the national lockdown.

1.6 On 19th March 2020, the care home had 33 residents. With the outbreak of the Covid- 19 pandemic, an additional 23 patients were transferred to the care home from other health care settings, mainly the two acute hospitals, Northamptonshire General Hospital (NGH) and Kettering General Hospital (KGH) between 19th March 2020 and 3rd April 2020. Care Home Selection Healthcare (CHS) were requested by Northamptonshire CCG to undertake these hospital transfers. Nationally, routine testing for Covid-19 pre-discharge was not in place at this time.

1 CCG – Became the Integrated Care Board in July 2023

[2] As of 1st April 2021, Northamptonshire County Council ceased to exist and was replaced by West Northamptonshire Council and North Northamptonshire Council. For the purpose of this SAR, Northamptonshire County Councill is referred to as the local authority.

[3] Local Resilience Forum – multi-agency partnerships that plan and prepare for localised incidents and catastrophic emergencies.

1.7 On 28th March 2020, the care home's Registered Manager reported to a Quality Improvement Nurse (QIN) from the CCG that the care home had one resident who appeared symptomatic of Covid-19 but that there were no other cases. On 3rd April 2020, the Registered Manager further reported, by email, that one resident had been transferred to KGH and two others were showing symptoms. Between 6th and 9th April 2020, several of the care home's staff members became symptomatic and started to isolate. Two further residents also became ill and one passed away. The Registered Manager began isolating on 9th April 2020 and informed CHS that the care home would not take any more new patients.

1.8 In April 2020, concerns were raised with CQC anonymously in relation to the residents at the care home and in particular around their nursing care, health needs, medicine management, wound care, nutrition and hydration needs. On 20th April 2020, a QIN contacted the care home and discovered the deteriorating situation. Issues within the care home were identified, such as a lack of risk assessments, no care plans, or care plans that had not been updated, food and fluid charts not completed, gaps in repositioning charts, no records of catheter changes, pressure wounds not appropriately treated and no mental capacity assessments or best interest decisions recorded.

1.9 Joint action between the Local Authority and the CCG subsequently led to a Health tactical team being deployed into the care home on 2nd May 2020, initially attempting to support it to care for its residents. Personal accounts from staff who went into the care home are distressing and harrowing. They recounted that some residents were found in wet beds with minimal clothing. Even those who could manage to drink for themselves had no access to fluids.

1.10 The review found that there was no evidenced contact between the care home and either the Provider Hub (part of the emergency Local Resilience Forum (LRF) response), the Local Authority or CCG from 6th April to 20th April 2020. There is also no evidence of contact between Amicura Limited's Area Manager, Operations' Manager or other senior staff from the company, with the care home or the Registered Manager during this period of time.

1.11 As a result of concerns held by the Local Authority and the CCG, a decision was taken on 11th May 2020 to transfer all remaining residents to alternative accommodation.

1.12 The context in which all organisations were operating during the period under review became more extreme and unprecedented as time progressed. A significant amount of central Government policy and guidance was being disseminated to the Health Service, Social Care and providers, and as more was learned about the Covid-19 virus, guidance was also frequently changing. Vaccines were not available, Personal Protective Equipment (PPE) was in short supply early in the pandemic, and the testing of patients and professionals was extremely limited.

1.13 It is acknowledged that there was a significant strain upon all agencies in respect of resourcing levels during this time and the sheer emotional impact of delivering care in these circumstances. There are several national reports detailing the experiences of staff working within care homes suffering from burn out and extreme stress. Likewise, the impact upon the residents within care homes and their families was immense.

2. Summary of findings

2.1 The review found that there was room for improvement in terms of the quality monitoring of the service provided by Amicura Limited and the care home, by the Local Authority and CCG which could have been achieved in a more joined up approach in relation to collation of all available information. This should include safeguarding concerns and soft intelligence.

2.2 Concerns in relation to the care home had been in evidence since 2019 and whilst improvements had been evidenced, there was still some inconsistency. The foundations of the service were not sufficiently established and robust when the national requirement to receive additional residents was made. The care home had a reliance on agency staff and there was a lack of effective management oversight and governance.

2.3 In respect of the care home it appears to the author that the admission of large numbers of patients in a short period of time in pursuance of the national approach to free up bed space created additional pressures for the care home. There was a lack of oversight of this process from the senior managers within Amicura Limited and within the LRF arrangements. The number and speed of discharges into the care home was inappropriate and there does not appear to have been any consideration given to the previous CQC inspection rating of "Requires Improvement" when determining the volume and specific needs of patients being discharged to the care home.

2.4 Whilst accepting that information and guidance were constantly changing, it appears to the author that the Infection Prevention Control (IPC) arrangements within the care home were ineffectual and the Health Protection team were unaware of the numbers of infections due to a lack of reporting from the care home itself.

2.5 There was a significant amount of information and support available for care homes but their involvement in the decision-making process of the emergency response was missing. A more proactive approach from the LRF, Provider Hub or Hospital Transfer Cell (HTC) to contact care homes on a more frequent basis may have identified the deteriorating situation earlier.

2.6 The quality of care provided to the residents was variable prior to the Covid-19 pandemic. Its significant deterioration during April/May 2020 was truly shocking and despite intervention and support from health colleagues it failed to respond and recover. Again, the oversight, governance and control by the service provider were absent. Residents within the care home were neglected and suffered significant harm as a result.

2.7 Many of the issues identified have led to change already but there is a significant national issue played out within this scenario in relation to the remuneration, training and career progression of care workers. Attracting and retaining quality nurses and care workers to the industry is a significant challenge and more needs to be done to ensure that our most vulnerable people receive the care they deserve and are safe.

3. The experience of the families

3.1 All of the families spoken to have expressed sympathy for the staff working within the care home during the difficult period of the first national lockdown, and have acknowledged that there were some excellent carers and nurses looking after their relatives.

3.2 The accounts and comments made through the report are those obtained directly from the families of residents. The families had no direct input to provide about the circumstances and situation apparent within the care home during the period of lockdown and their observations are based upon, in the main, telephone contact with the care home, their experiences outside of the care home, and as it was closing. The main concerns experienced by families of residents at the care home included:

a. Poor planning prior to discharge from hospital about next stage in a resident's care journey with little or no prior discussions with families about choice of care home. It should be noted that the Covid-19 Hospital Discharge Requirement removed patient choice due to the emergency pandemic situation. Lack of patient choice was also a feature when residents were transferred from the care home.

b. Poor care standards generally. Some residents were left with little stimulation, poor nutrition and hydration to the extent that some residents experienced very significant weight loss. Staff seemed to pay little attention to the personal appearance of residents with reports of matted hair, residents generally looking unkempt and poor standards of room cleanliness. Medication management was also a challenge, with one resident having their medication reviewed and re-balanced completely on admission to a hospice when the care home ceased operations.

c. Management and staffing levels were identified as a challenge by one of the relatives of a longer-term resident dating back to when the care home opened anew in 2018. Recruitment and retention appear to have been a problem as staff changed very regularly and comments were made by several of the families regarding the frequent changes of Registered Manager. Towards the end of the care home's operations, the staff team seemed to consist mainly of agency staff who had very little knowledge of the residents.

d. Communications with the care home, particularly during the lockdown period of Covid-19, were very challenging. Standard and 'pat'/stock answers were given in response to enquiries by families, particularly about Covid-19 being in the home.

e. Visiting arrangements, whilst relatively satisfactory prior to Covid-19 lockdown, seemed to be very difficult during lockdown, even for end-of-life residents, and some families experienced difficulties when wanting to contact their relatives via telephone. There appears to have been a lack of opportunity offered to use technology to facilitate remote contact.

f. Families felt that the problems being experienced by the care home were self-evident and could not understand why the care home and the owners had not sought help a lot sooner with the challenges they were facing. Relatives also found it difficult to understand why statutory agencies had not acted sooner than they did.

The main themes from the review are summarised below.

4. Quality monitoring, oversight and regulation

4.1 The recent history of the care home appears to indicate a care home that had experienced reoccurring issues particularly in relation to its patient care, retention of staff and the oversight and governance provided by its senior management.

4.2 There was a chaotic approach to the monitoring of progress against the action plans required by the CQC, CCG and Local Authority and whilst there were regular information sharing meetings between these organisations taking place to monitor the quality and safety of providers, it is evident that not all information or soft intelligence was considered.

4.3 As the first wave of the pandemic took hold, the quality monitoring process was mainly conducted via the telephone, although the two QINs from the CCG did continue to visit providers where necessary. The CQC suspended its inspection activity.

5. Hospital discharges and admissions

5.1 The review looked at the impact of the national requirement to discharge medically fit patients from hospital settings on all of the organisations involved. The national discharge requirement came into effect on 19th March 2020 and removed the patient's choice. The guidance that accompanied the requirement suggested that the majority of patients would access Pathway 0 and return to their own home.

5.2 The review could not establish the specific percentage of patients that accessed each pathway. However, a number of the families who provided information for the review had expected that their relative would return home, however, instead they were transferred to the care home.

5.3 The overall system adopted to discharge patients quickly and in large numbers was developed at a time of national emergency. However, the system that operated locally within Northamptonshire to facilitate that requirement would have benefitted from greater oversight from both the LRF, HTC, Provider Hub and the senior management of Amicura Limited / Minster Care.

5.4 The speed of discharge also meant that the initial information provided from the hospitals about a patient's needs was suboptimal in many cases, and it took several weeks for social care assessments to commence once the resident was moved to the care home.

6. Infection prevention control

6.1 The role of Public Health was at the heart of the national response to the pandemic. The responsibility for IPC within a care home falls to the Registered Manager.

6.2 National guidance was continually changing around the wearing and use of personal protective equipment (PPE) and understanding about the spread of the virus was developing all the time.

6.3 Access to PPE was available through various local channels although Amicura Limited told the review that there was difficulty in obtaining PPE and they sourced some of their own.

6.4 The routine testing of patients leaving hospital settings in Northamptonshire commenced on 20th April 2020.

6.5 Practitioners told the review that the IPC measures within the care home were not sufficiently embedded and that despite guidance issued by senior management and their assertion that appropriate measures were in place this was clearly not adhered to. With a lack of oversight and checking from senior managers that their directions had been implemented, the evidence suggests that there was no control over the spread of infection within the care home. Steps to rectify this were taken when the care home was supported by additional staff and a manager towards the end of April 2020.

7. Guidance, support, management oversight and grip

7.1 Through the development of the emergency response and the LRF structure in Northamptonshire, a Provider Hub was created to support and disseminate guidance to all providers. However, there was no care provider or care association represented in the LRF structure so they could not directly influence any of the local decision making.

7.2 The Provider Hub circulated information about how support could be accessed and required providers to inform them of any business critical issues and sight of their business continuity plans. The business continuity plan was not forthcoming from the care home.

7.3 There is evidence of many briefing documents that were circulated to the providers but no evidence of weekly calls to them.

7.4 The critical time period within this review is between 19th March 2020, when new residents began to arrive at the care home, to 20th April 2020, when the deteriorating situation was identified.

7.5 There were missed opportunities between 3rd and 6th April 2020, when the Registered Manager notified the Local Authority and the CCG that there was a confirmed case of Covid-19 within the care home, and three other residents had been admitted to hospital.

7.6 Amicura Limited's senior management team had a vital role to ensure that they were able to manage an appropriate and safe service for their residents. It is the provider's responsibility to ensure that through appropriate planning and testing, their service can remain operating safely. They did not have the appropriate level of oversight and management of this deteriorating situation.

8. Quality of care and culture

8.1 The CQC set out clearly what individuals should expect from a good care home and use this as a basis for their inspection. Within their safety standard are a number of points including that the care home and any equipment are well maintained, there are always enough staff on duty with the skills needed to make sure residents feel safe, residents are regularly asked about choices and views, and that the staff have the right knowledge, qualifications and skills to carry out their role so that you have a good quality of life[4].

[4] The fundamental standards | Care Quality Commission (cqc.org.uk)

8.2 When the deteriorating situation within the care home came to light, many of the aspects identified within the CQC's standards appear to have been absent.

8.3 Issues relating to the quality of care were identified to the author by the families contributing to the review and these were evident prior to the pandemic. A lack of attention to basic personal care and poor standards of hygiene within residents' rooms and bathrooms were highlighted.

8.4 Agency staff who attended the practitioners' learning event reported that they had no access to the residents' care plans and they gave examples of residents running out of medication and equipment that was not working. The agency staff said that they felt they were not listened to.

8.5 When statutory agencies did intervene, the QIN reported on 30th April 2020, there was again a lack of risk assessments, either no care plans or care plans not updated, food and fluid charts not completed, gaps in repositioning charts, no records of catheter changes, pressure wounds not appropriately treated and no mental capacity assessments or best interest decisions recorded.

8.6 Many of the existing residents at the care home were frail and suffered from dementia, therefore doubling the capacity at the home in around two weeks appears to have put a significant strain on the existing staff resulting in their inability to provide basic care. However, the basic provision of nutrition, hydration and personal care had all featured in action plans prior to the pandemic, hence there is likely to be a pre-disposition to similar issues re-occurring.

8.7 The care home had an over-reliance on agency staff and numbers of staff on duty at any given time was examined in some detail. There was also an absence of managerial structure present within the care home once the Registered Manager became ill and began isolating herself.

8.8 The reliance upon agency staff within the care home belies a more fundamental and national issue which this review highlights. The ability to recruit and retain quality staff within the sector is increasingly difficult and is clearly linked to the standard and quality of care being provided. This point leads to a recommendation designed to continue the conversation with national government departments to address the lack of professional pathways, career structure and remuneration surrounding the social care workforce.

9. Safeguarding, Whistleblowing and intervention

9.1 The CQC alerted the Local Authority safeguarding team to two anonymous safeguarding reports made on 13th and 15th April 2020. The first stated that there was a lack of continence care for residents, call bells had been removed by staff, the home was understaffed, and people were leaving. Residents had unexplained bruising to their bodies and staff were not ensuring that residents were taking their medication. There were also concerns about the food and fluids being provided and a lack of utensils for eating. The CQC emailed the Registered Manager about this but received no response.

9.2 The second report made to the CQC on 15th April 2020, reported that staff were leaving, and the home was being predominantly run by agency staff. There was concern that residents may be suffering from abuse due to the unexplained bruising seen.

9.3 There had been two previous whistleblowing reports made to the CQC in January and February 2020 and the Registered Manager had also made a safeguarding referral in January relating to the management of medicines.

9.4 A further two separate concerns were raised in March 2020 by East Midlands Ambulance Service and an NHS 111 member of staff in relation to specific individuals within the care home.

9.5 Upon discovering the situation in late April the Local Authority, CCG and CQC worked together in an attempt to support the care home. A tactical health team were deployed into the care home on 2nd May 2020.

9.6 Amicura Limited provided the review with their generic safeguarding policy which did not contain current terminology. It is the author's opinion that it is not possible to demonstrate that safeguarding was understood and embedded within the care home. Of concern is that the condition of some of the residents suggest an indifference and lack of empathy and care.

9.7.1 Amicura Limited had a whistleblowing policy, but concerns were articulated by agency staff who attended the practitioners' learning event, that they were not confident in using the provider's own process exhibited by those trusted to look after them.

9.8 In relation to the culture within the care home, as identified from the practitioners' learning event, agency staff felt that they were not listened to and whilst they did make some reports about lack of equipment and medication, they felt nothing was done and no action was taken. They also described feeling fearful that they would be seen as troublemakers and would not be employed in the future.

9.9 Care homes became closed environments during the first wave of the pandemic which meant that the standards and the quality of care within a care home were not being observed by others, including families and other visiting professionals. The fact that two whistleblowing reports made within the space of three days did lead professionals to enquiring further, and with the intervention of the QIN, there followed a significant period of intervention, support and safeguarding.

9.10 At the time of the intervention, contact with the residents' families was lacking in detail and information. Some families said that they found out about the situation and the movement of their relative only after it had occurred, and again the lack of choice was evident. A clear, organised communications strategy could have helped this situation and begun to rebuild the trust of families.

10. Recommendations

1. The Local Authorities and ICB, who are members of the Quality Monitoring Board, should provide assurance to NSAB that there is an effective system in place to identify where enhanced support and increased monitoring is required, for providers that are graded as "requires improvement", "inadequate" or where there are other early warning signs or indicators poor quality and/or safety.
2. NSAB should engage with the chair of the Local Resilience Forum and the members forming the strategic co-ordinating group to disseminate the learning from the review to ensure that within the emergency procedures risk management process the impact of any national policy is examined against the local context and consequences are understood and closely monitored.
3. The ICB and the Local Authorities should provide assurance to NSAB that they have arrangements within their commissioning and contract monitoring processes to ensure providers engage with the process, under any type of contract, including spot purchase provision and have effective IPC arrangements in place, not only through effective contingency planning policies but that it can be practically demonstrated by the provider.
4. Learning from the review should be disseminated to all Northamptonshire care providers and they should demonstrate learning from the pandemic and other relevant reviews by updating contingency plans. This should be monitored by the ICB and local authorities during quality and contract monitoring.
5. NSAB to seek assurance from the LRF chair as to how the points of learning from this review, in relation to the inclusion of health and care providers as key stakeholders in the development of emergency procedures.
6. The ICB working with the local authorities should commission a plan for introducing effective & timely EHCH arrangements and provide assurance to NSAB on the implementation within the county.
7. The CQC to consider that when a service provider is registered and inspected, that the management structure of a service is assessed in relation to whether the senior management structure is appropriately resilient to ensure it is sufficiently robust to provide the necessary oversight and governance on a practical level.

8. The Local Authorities and the ICB should assure NSAB of their support and influence to assist care homes in developing the quality-of-service provision through engagement in any Registered Manager Forum, provider forums, training events, or care association network.

9. NSAB will use the agreed National Network of Safeguarding Adult Board Chairs' Escalation Policy, when necessary, to raise issues through the network to the Department of Health and Social Care with specific focus upon the challenges in the recruitment and retention of quality staff, the over-reliance on agency staff to fill vacancies, and the national problem of the remuneration and working conditions of care workers leading to overall poor quality care.

10. NSAB should seek assurance through the Local Authorities and the ICB that commissioned service providers have current safeguarding policies in place, that are accessible to residents, staff and families and that the policy is understood and implemented.

11. Additional comment concerning Amicura Limited

Each agency involved with the review was asked to agree the report before the final report was sent to NSAB.

Amicura Limited have written to the author to express that they consider that they were not able to agree the report due to their concerns as to the approach and lack of impartiality of the review. Specifically, they have expressed the view that throughout the various drafts the presence of confirmation bias has unfortunately been increasingly obvious in responses to the comments raised by them. In addition, Amicura Limited stated that the draft retains a scepticism of the concerns reported regarding pressure being brought to accept discharges but that such scepticism is not found in relation to reported quotes in the report that are critical of the service.

The author has carefully considered all of Amicura Limited's comments throughout the review and is content that the review has been appropriately conducted.

The CQC brought a prosecution against Amicura Limited and on 23rd May 2023 Amicura Limited pleaded guilty to four charges relating to a failure to provide safe care and treatment to residents. A copy of the CQC press release in respect of this case be found here: Amicura Limited ordered to pay £200,181 after failing to provide safe care and treatment - Care Quality Commission (cqc.org.uk).