Key findings and learning from Safeguarding Adults Review (SAR) 021
Treatment of residents at Temple Court Care Home – October 2023

Sharing Learning

This learning briefing summarises the key findings from the Safeguarding Adults Review (SAR) concerning the treatment of residents at Temple Court Care Home, Albert Street, Kettering between January and May 2020. It aims to identify both good practice and areas for improvement. We kindly request that managers discuss this with their teams to ensure that the learning is used to enhance existing good practice and to make improvements where necessary.

Background to Safeguarding Adults Review (SAR)

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

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 organisations in relation to the progress of the required improvements and in response to some whistleblowing and safeguarding concerns.

The first two confirmed cases of Covid-19 were reported in the United Kingdom 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 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.

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

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.

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, she 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 more new patients.

In April 2020, concerns were raised with the 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

[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.

the care home were identified 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.

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.

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.

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.

19 residents sadly died during the time period under review. Four of those were recorded as attributable to Covid-19.

SAR Findings

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.

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.

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 Local Resilience Forum (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.

Whilst accepting that information and guidance was 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.

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 to contact care homes on a more frequent basis may have identified the deteriorating situation earlier.

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.

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 value of our care workers. In particular their remuneration, training and career progression. 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.

Key Points – Learning in relation to the quality monitoring process for providers

1. The quality monitoring process for providers needs to be co-ordinated and consider all available information. Action plans should be consolidated where possible.
2. An effective quality monitoring system in place is vital to ensure the safety of residents and to ensure they receive appropriate care. To achieve this there must be co-ordination between the commissioners and regulators of services which uses all available information from professionals, residents and families to shape that understanding. Safeguarding reports and whistle blowing must feature in that overall picture providing an early warning system that standards, quality and safety may be at risk.
3. Providers that are rated as "Requires Improvement" or "Inadequate" should receive regular monitoring and risk assessment with a 'turn-round' improvement plan with external support, as necessary, to achieve acceptable standards of care and wellbeing.
4. With the development of the Integrated Care System[4], between health and social care organisations imminent, there is potentially an opportunity for a more co-ordinated approach to the quality monitoring system. A new care model developed within Cambridgeshire and Peterborough[5] has increased the number of CCG Quality Improvement Nurses and created a joint Care Home Support

Key points – Learning about hospital discharges and admissions

1. 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.
2. In any similar scenario where there is either a need to move a significant number of patients into a care home setting or another emergency situation, there must be multi-agency agreement relating to the selection of care homes. Placements must be subject of a risk assessment based on all available information to ensure that the care home can meet the needs of residents and are safe, and in particular, where a care home has a rating of "requires improvement" there should be multi-disciplinary discussion on whether enhanced support is required and what form this would take. Information provided to the author by the CCG reports that local intelligence gathered from information sharing and monitoring processes is used when commissioning placements and closer monitoring is given to care homes that are rated as 'Requires Improvement' with supplementary visits taking place at regular intervals.
3. 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. Amicura Limited have informed the author that it is their usual practice to attend hospital and carry out their own assessments prior to accepting someone into their care. This could not happen due to Covid-19 and so they were reliant upon information from other professionals. Amicura Limited reported that they were frequently given incorrect, incomplete or no information upon a patients discharge from the hospital to the care home and it was therefore difficult for residents to receive personalised care and for their needs to be appropriately met when admitted. NGH state that there is no evidence to support Amicura Limited's position about being given incorrect, incomplete or no information about a patient. However, once the care home got to know the residents, there should have been opportunity for their needs to be reviewed.
4. The discharge to assess model could be extremely beneficial in terms of patients being able to leave hospital sooner provided that the placement they are discharged to is the right setting and care is personalised to their needs.

Key points – Learning about infection prevention control

1. Multi-disciplinary meetings in relation to notifiable outbreaks of Covid-19 were good practice and delivered the necessary responses to assist in many locations not just care home settings. Learning from outbreaks and appropriate responses should be disseminated to all health and care settings.

[4] Integrated care systems (ICS) are new partnerships which will be established in law, between the organisations that meet health and care needs across an area to co-ordinate services.

[5] Cambridgeshire and Peterborough CCG – Model of support to Care Homes

2. Effective IPC must form part of embedding a culture of safety throughout care homes in general with appropriate training for staff and regular updating of current practice. Familiarising all staff (including agency staff) with correct procedures and use of PPE is essential.
3. Current and relevant risk assessments are needed to ensure the safety of residents, staff and visitor and effective communication with families and residents about IPC measures is also important.
4. Senior managers of care homes need to ensure that as well as policy and guidance being available they must check that IPC is embedded, and operationally is happening.
5. Sound IPC measures are not only relevant to a pandemic such as Covid-19 but can be necessary in relation to many other transmittable diseases. Building the requirement to have effective IPC measures in place into all contracts and ensuring an annual compliance test could help raise the importance of such measures.
6. Care homes would also be wise to ensure within their contingency planning that they have an effective outbreak planning assessment to ensure that measures are put into place quickly and staff are clear about roles and responsibilities. The CQC Guidance for providers gives a detailed list of questions that can be used to assess whether the providers IPC arrangements are effective.

Key points – Learning in relation to guidance, support, management oversight and grip

1. The health and social care providers, which includes residential care homes, in the County were key stakeholders in the development of the response to the Covid-19 pandemic in Northamptonshire. They had no direct input to the LRF or opportunity to influence local policy decisions or flag potential issues.
2. In reviewing the County emergency procedures consideration should be given to involving care providers as key partners in the LRF structure with provider representation at tactical and strategic level. Whilst there were weekly provider forums, there was no evidence of a care association representative or other nominated representative within the LRF arrangements which could lead to more effective communications, a better early warning system and identification of risk.
3. Good practice identified in various areas throughout the country would suggest that proactive and regular telephone calls/video calls to care homes is essential and in some Local Authority areas calls were made on a daily basis. The CCG's Chief Nurse and Quality Officer held twice weekly Teams forums during the pandemic for all care home and domiciliary providers to support them and offer an opportunity to discuss issues and help with process, however there is no evidence to show that the care home accessed these sessions. Monitoring the uptake of this support may also provide a useful indicator and prompt further action and reach out from the statutory partners.
4. Proactive senior management within care homes is essential to the safety and quality for residents. It should be a key area for all providers to update their business continuity plans and processes through learning from the pandemic and from reviews such as this.
5. The overall governance and structure of a provider should form part of the assessment criteria, regulatory oversight and contract management processes to identify whether a management structure is too lean to be effective.
6. Inspection of providers business continuity plans and processes should form part of the regulatory and quality monitoring system to ensure that providers understand their obligations and are as prepared as possible to meet foreseeable challenges.
7. Developing the provision of health care through the "Enhanced Health in Care Homes" framework (EHCH) will provide a more person-centred approach to the needs of all residents, together with clinical support to Care Home Managers, nursing and care staff and a more proactive service if care homes are aligned with Primary Care Networks.

Key points – Learning with regard to the quality of care and culture

1. It is a provider's responsibility to ensure a good level of safe care for their residents and the culture is set by senior management and Registered Managers within homes. An active Registered Managers network, provider forums and the influence of local care associations can all have a significant impact upon the quality of care and gives commissioners an opportunity to engage and influence.

2. The NICE guidelines[6] published in 2021 identify that it is the responsibility of the Registered Manager to ensure that agency staff have completed the necessary training for their role and understand the local multi-agency safeguarding policy and procedure[7].
3. Training for agency staff should replicate that of employed staff. Care homes should assure themselves that agency staff are as well trained as their own staff and provide any additional local input as necessary. It is a requirement under Regulation 18 from CQC that providers ensure their staff are appropriately trained, supervised and received Continuous Professional Development[8].
4. Adoption of the Code of Conduct for Healthcare Support Workers provides a framework for the conduct and professionalism of care workers including their accountability.
5. The culture within the care home as described by practitioners indicates that despite raising issues with senior staff, no action appeared to be taken. A more open, transparent and responsive culture needs to be a priority.
6. Amicura Limited detail within their Coronavirus contingency plan that relatives of residents could be asked to assist the care home in times of emergency. This was also suggested by one of the contributing families and could have been a very effective way of providing some basic care. However, it should be acknowledged that the Government guidance published shortly after the commencement of the first national lockdown advised that family and friends should not visit care homes except the next of kin, and in exceptional circumstances such as end of life.
7. Communication to relatives from the care home could and should have been better. An individual dedicated to maintaining contact with the families during the closure process would have helped their understanding significantly.

Key points – Learning in relation to safeguarding, whistle-blowing and intervention

1. A current safeguarding policy that is available to all staff, residents and families must be maintained by providers. Ensuring staff understand what constitutes harm and abuse and the action they must take must feature significantly in their mandatory training and be supplemented by support from statutory agencies and the safeguarding board. A useful guide for Registered Managers is available from SCIE.[9]
2. Amicura Limited are encouraged to make a commitment to update and disseminate their safeguarding policy to staff. Publishing the policy on their group website would also allow residents, families and other interested parties to have an understanding of safeguarding
3. The safeguarding process should be seen as a supportive process and not adversarial. Providers should supply relevant information to safeguard adults at risk and then drive necessary improvements. The quality monitoring process used by commissioners of service should be used to identify whether the learning from safeguarding enquiries has been embedded.
4. Information provided to the families and their involvement during the movement of residents from the care home following the intervention of the Health tactical team could have been managed in a more sympathetic way by allocating individuals from Amicura Limited and the Health tactical team to carry out this communication role.
5. The deployment of the Health tactical team into the care home was a new process but during the review it became apparent that there was a difference in opinion about the roles and responsibilities of the parties involved, with Amicura Limited stating that the Health tactical team was responsible for the running of the care home. This was not the understanding of the Health tactical team and the CCG have stated to the review that the tactical team strayed beyond their original remit due to residents being at risk and an emergency response was required for patient safety. They had a duty of care to the residents, professional accountability and responsibility to safeguard them. The CQC have stated to the review that the deployment of the community nurses into the care home was to implement clinical oversight, monitor people's safety and to safeguard people. The CQC state that the registered provider remains legally accountable for the running of the care home. It would be beneficial if this arrangement was documented and roles and responsibilities clearly articulated at the start of the deployment.

[6] Safeguarding adults in care homes (nice.org.uk)

[7] These multi-agency policies and procedures are the local adult safeguarding policy which all organisations are required to follow**.** Each agency and organisation operating in the area should develop their own arrangements for safeguarding to complement but not over-ride the multi-agency policy

[8] Continuing Professional Development or CPD is a self-tracker of an employee to continuously improve professionally.

[9] Creating-a-safeguarding-culture.pdf (nice.org.uk)

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 rated 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 should 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 and 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.

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