# The Amwell Care Home Limited

# The Amwell

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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| Is the service safe? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
The Amwell is a residential care home providing personal care to 51 people aged 65 and over at the time of the inspection. The service can support up to 88 people.

The Amwell accommodates people in one adapted building split into four floors. At the time of inspection three floors were being used. Each person has their own bedroom with an en-suite bathroom. On each floor there is a shared lounge, dining room with a kitchenette area and bathroom. There is a communal garden, bistro, gym, cinema and salon/spa area for people to access.

People's experience of using this service and what we found
People were not always safe. At the time of inspection, a COVID-19 outbreak was affecting two of the three floors. Infection prevention and control practices continued to be poor at the service, and staff failed to use Personal Protective Equipment (PPE) in accordance with national government guidance.

People were not always protected from the risk of harm and abuse. Care plans did not reflect people's needs and risk assessments did not identify or provide guidance on how to mitigate areas of risk.

People did not always receive their medicines safely.

People were not always supported by adequate staffing levels. Staff did not always have the necessary training and experience to safely provide the care people required.

The service was not well-led. The management team had undergone changes but still did not have oversight or awareness of concerns, risks and incidents that had taken place across the service. Quality assurances and processes were not always robust or effective at identifying areas of concern, and improvements to the service were not always made.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was Inadequate (published 10 September 2020).

Following this inspection the service was placed in special measures. We imposed conditions on the provider's registration in August 2020 as they were in breach of the regulations. The provider completed an action plan after this last inspection to show us how they would meet these conditions. A monthly report was sent to CQC detailing progress on medicine administration and auditing processes, staffing levels and review of care plans and equipment. At this inspection not enough improvement had been made or sustained by the provider, therefore the service was still in breach of regulations. The service retains an Inadequate rating.

At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We received concerns in relation to the COVID-19 outbreak and whistle blowing concerns about neglect and staff failing to use equipment people had been assessed as needing. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has remained Inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Amwell on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to infection prevention and control; assessing care plans and risks; medicine administration; safeguarding people from abuse and harm; staffing and governance of the service.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

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| **Is the service safe?**<br>The service was not safe. | **Inadequate** |
| **Is the service well-led?**<br>The service was not well-led. | **Inadequate** |

# The Amwell

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by three inspectors.

Service and service type
The Amwell is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of inspection however the registered manager was absent from the service and a peripatetic manager and regional manager were overseeing the service.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with 22 members of staff including the peripatetic manager, regional manager, assistant manager, senior care workers, care workers, house keepers and agency staff. Due to the COVID-19 outbreak we were unable to speak with people using the service.

We reviewed a range of records. This included ten people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We spoke with three relatives to gain their views. We also spoke with the nominated individual and the quality director to share findings from the inspection. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Inadequate

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

At our last inspection we found the provider was not providing safe care and treatment was in breach of regulation 12 (1) Safe care and treatment and of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Preventing and controlling infection

- People continued to be placed at risk of acquiring COVID-19. Despite a significant COVID-19 outbreak at the service, staff failed to use Personal Protective Equipment (PPE) in line with national government guidance. Staff were observed handling breakfast without wearing gloves and moving between people's bedrooms without changing PPE or washing/sanitising their hands. This placed people and staff at risk of contracting and transmitting COVID-19.
- Staff did not know which people were positive for COVID-19. This meant staff were not able to protect people and staff from the risk of contracting and transmitting COVID-19. Management were made aware of this and placed information about isolation period start and end dates on COVID-19 positive people's bedrooms doors. Staff however still did not consistently know which people had COVID-19 and required particular care interventions which placed people at an increased risk of contracting and transmitting COVID-19.
- COVID-19 positive people were not safely barrier nursed in their bedrooms. Doors were left open, and people moved around the service unobserved by staff. This meant there was a risk of COVID-19 being transmitted to people who did not have COVID-19.
- People did not have COVID-19 specific care plans and risk assessments in place. This meant staff did not have the guidance to safely meet people's needs.
- Agency staff told us they were not working exclusively at the service and had not been tested regularly for COVID-19. Management had been made aware of these problems and spoken to the agencies, but these issues persisted. Systems to monitor agency staff work practices were not in place which increased the risk of COVID-19 being contracted and transmitted to people and staff.
- During the COVID-19 outbreak staff were allocated to floors to minimise the risk of people and staff contracting and transmitting COVID-19. We found however, instances where staff were required to move between floors to administer medicines.

Assessing risk, safety monitoring and management

- People's needs were not always safely assessed or managed. Staff did not consistently recognise deteriorations to people's presentation which meant opportunities to manage and redirect people were missed, and avoidable incidents occurred. For example, one person was involved in 24 incidents where other people and staff were exposed to and experienced physical and sexual assaults. Failure to manage

this risked placed people at risk of harm.
● People did not consistently receive support and care they required. For example, one person had been assessed as requiring a door sensor to alert staff to their movements to minimise the risk of falls. On two occasions staff failed to activate the door sensor which meant staff were not aware the person had left their bedrooms. On both occasions the person experienced falls. Staff failed to follow care plans and steps to mitigate known risks which meant people were placed at significant risk of avoidable harm.
● Staff did not alert other health care professionals to changes in people's needs in a timely manner. In some instances, people's relatives identified areas of concern that staff had not. This meant that people were not always receiving care that was reflective of their changing needs.
● Care plans and risk assessments were not always accessible to staff. Not all staff were able to access the record systems which meant they were not always aware of changes to people's care needs. This also meant that accurate information was not entered into the system in a timely manner. Hand held devices designed to make recording more efficient were not always charged or working which impacted upon staff being able to record information.

Using medicines safely
● People did not always receive prescribed medicines. For three days in October approximately 25 people were without prescribed medicines due to an error at the pharmacy. Whilst this was not the service's fault, there was no contingency in place to ensure adequate stocks of medicine were available. People who required medicines to treat Epilepsy, Parkinson's Disease, Bipolar Disorder and pain management did not have access to the medicines they required. This meant people were unnecessarily exposed to risk of physical and mental health deterioration.
● Staff were not always able locate medicines. One person's MAR charts identified they had not received medicines for agitation and a cognitive disorder as staff were not able to find where the medicines were. This meant people did not have access to the medicines they required which may have impacted upon their mental health, behaviours and presentation.
● People did not always receive prescribed medicines safely. One person received their medicines concealed in food. While a conversation had taken place with the GP surgery regarding this practice, there were no care plans, risk assessments or protocols in place to ensure staff did so safely.
● Processes around safe administration of medicines were not always followed. Medication Administration Record (MAR) charts showed some medicines required two staff to administer them, MAR's showed these were often administered by one member of staff. Some people also refused medicines for three days in a row which were then not followed up with a GP contact as per the provider's policies. One person refused medicines for their health condition on ten occasions during November 2020 which may have led to their health needs deteriorating.

Learning lessons when things go wrong
● Lessons were not learnt and the opportunities to prevent incidents from occurring again were missed. This placed people at risk of avoidable harm and demonstrated the provider lack of oversight to improve the quality of care that people received.

Systems were either not in place or robust enough to demonstrate safety was effectively managed and people were at risk of harm. This was a breach of regulation 12 (1) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection we found the provider was not providing safe care and treatment was in breach of regulation 18 (1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not

enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● There were not enough staff to safely meet people's needs. A staff member told us "Due to staff shortages we are not able to meet [people's] pad changes, fluid recordings and other tasks. I prioritise those with the highest need first and work down from there to the lowest need. It's not right and I feel guilty but we are caring people." Another member of staff said cover was not provided while they went for their breaks. This meant people could not access support for approximately 30 minutes at a time and were exposed to unnecessary risk and harm.
● Staff did not always have relevant training required to perform their roles. For example, staff had not had any safe break away training which allowed them to safely care for people who displayed behaviours that challenge. Specific COVID-19 training had not been provided to the whole staffing team. This meant people were not always supported by staff who were aware of and understood best practice.
● Agency staff were not always competency assessed. We found agency staff administering medicines had not been assessed by the service to be safe to do so. Following the inspection, we requested details of competency checks but these were not provided. This meant people may not have been cared for by staff with appropriate skills and knowledge.

The provider failed to ensure there were enough staff to safely meet people's needs. This is a breach of Regulation 18(1) Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

● Processes to safely recruit staff were followed.

Systems and processes to safeguard people from the risk of abuse
At our last inspection we found people were not being safeguarded from the risk of harm. This was a breach of regulation 13 (1) Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

● People were not safeguarded from the risk of avoidable harm. Whilst systems were in place, staff did not consistently identify instances where people were at risk of abuse and avoidable harm. Records showed one person had been physically aggressive towards people and staff on eight separate occasions. There was no evidence incidents had been reported to the local authority or risk assessments had been updated accordingly. This meant opportunities to reduce the risk of harm were missed and people were unnecessarily exposed to abuse and avoidable harm.
● Some staff did not always conduct themselves in an appropriate manner. The regional manager told us they had heard staff swearing in areas where people would be present. This had been raised as a concern at the previous inspection but had not been fully addressed.

Systems were either not in place or robust enough to ensure people were protected from abuse and improper treatment. This was a breach of regulation 13 (1) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had implemented a 'Safe Call' system where staff could raise whistle blowing concerns if necessary. This is an independent whistleblowing hot line.

Inadequate

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to ensure systems and processes were in place to effectively assess, manage and communicate risk, as well as implementing processes to affect positive change. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There had not been enough improvement made at this inspection the provider continued to be in breach of regulation 17.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The service was not well-led. Measures were in place including daily flash meetings, team meetings via Whatsapp and weekly MDT meetings. Changes to the management structure had also occurred, but the management team still did not have oversight of the service despite these measures being in place.
For example, the management team were not aware of practice and concerns on each floor as staff were not cohorting and were working between the floors through the COVID-19 outbreak. This meant the day to day running of the service was not reviewed, key challenges, risks and concerns were not known and opportunities to improve care were missed.
- Quality assurance processes were not robust and did not address areas where improvements could be made due to lack of oversight. For example, compliance with PPE was raised by CQC inspectors rather than being addressed appropriately or thoroughly by the management team. Systems management put in place to improve areas were not robust and changes that were required to improve practice did not occur in a timely manner.
- Information was shared with relatives via telephone calls, weekly news letters and a monthly newsletter. Some relatives felt however information was not always consistently and regularly shared regarding their family member's health needs.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Systems were not in place to evidence the provider had carried out their duty of candour. Incidents where people had experienced abuse or harm were not consistently reported and evidence was not available to demonstrate a thorough investigation had taken place.

Managers and staff being clear about their roles, and understanding quality performance, risks and

regulatory requirements
● A peripatetic manager was in place as the registered manager was no longer at the service.
● Staff received supervision and informal chats. Records indicated these were taking place with staff. Some staff had failed to use PPE appropriately and disciplinary processes were being initiated by the management team.
● Communication was not effective between management and staff. During the inspection, management and staff were not able to provide consistent information to questions that were asked. For example, the peripatetic manager understood which people were in isolation for COVID-19 positive tests, but assistant managers and staff did not know which people were.
● Not all staff felt valued or listened to. Some staff felt able to approach management and share difficulties, but one member of staff told us management do not listen to concerns and said "Nothing changes."

Continuous learning and improving care
● Audits and quality assurance were carried out, but did not demonstrate how lessons were learnt or how this information was communicated to staff. This meant that opportunities to learn and improve care and the service were missed.

Working in partnership with others
● Improvements had been made to the working relationship with the local GP practice since the last inspection. Weekly multi-disciplinary meetings to share information took place, however partner agencies told us information was not always accurate or good quality. This meant that measures to improve people's care was not always considered and implemented in a timely manner.

Systems and processes were either not in place or robust enough to demonstrate the regulatory activity was effectively managed. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did not always notify CQC of reportable incidents that was required. We found instances relating to safeguarding concerns that had not been reported as per CQC regulatory requirements.
● The peripatetic manager advised that reflective meetings with staff would be implemented, however plans had not yet begun due to the recent COVID-19 outbreak at the service
● The management team were proud of how the staff had pulled together through the COVID-19 outbreak. The management team told us staff had worked hard and they kept in touch using a Whatsapp group. Staff told us they felt supported by the management team and were able to raise concerns if they had any. Some staff told us they had yet to meet the peripatetic manager due to the COVID-19 outbreak.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Weekly communications and news letters were sent to relatives. Relatives told us they received updates from the service although one person told us they felt communication was not always consistent.