Melton Care Limited

The Amwell

Inspection report

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Date of inspection visit:
29 June 2020
06 July 2020

Date of publication:
10 September 2020

Ratings

Overall rating for this service	Inadequate

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 people aged 65 and over. At the time of inspection, the registered manager was not certain about the actual number of people living there. We believe there were 69 people using the service. The service can support up to 88 people.

The Amwell accommodates 69 people (we could not be certain of this number) in one adapted building, separated on four floors. Each person has their own bedroom with an en-suite bathroom. There is a shared lounge, dining room and kitchenette area on each floor. People are also able to access a shared garden, cinema, bistro, gym and salon/spa area.

People's experience of using this service and what we found
People were not always safe. People were unnecessarily exposed to the risk of Covid-19 because management and staff were not wearing the Personal Protective Equipment (PPE) they were required to. It was identified that the registered manager, management team and staff were complicit in deceiving the inspection team during the inspection site visits about the use of PPE .

People were not consistently protected from the risk of harm and abuse. Risk was not always identified or managed. People did not always receive their medicines in a safe way.

People did not always have their needs met because there were insufficient numbers of staff with the right skills to meet their needs. There was not enough equipment such as hoists and standing aids and this resulted in people having to wait a long time for staff to meet their needs. On one floor there was only one hoist for 12 people who required this equipment for all of their mobility needs.

The service was not well-led. The registered manager did not have oversight of the service. Quality assurance processes were not consistently used and were not robust enough to identify areas of concern.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

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

Rating at last inspection
The last rating for this service was Good (published 20 May 2019).

Why we inspected

We received concerns in relation to the management of pressure wounds, monitoring of weight, monitoring of nutrition and hydration, collaboration with health and social care professionals, the use of PPE and safeguarding adults investigations. 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 changed from Good to Inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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 control practices (the use of PPE); safe care and treatment (medicine administration, following care plans, lack of equipment); staffing and governance.

Please see the action we have told the provider to take at the end of this report.

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.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore 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.

Is the service safe?

People were not kept safe.

Inadequate

Is the service well-led?

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.

Inspection team
Two inspectors carried out the inspection. An additional inspector and two assistant inspectors worked remotely to review documents and speak with staff and relatives.

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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the provider since the last inspection. We sought feedback from partner agencies and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We spoke with 19 members of staff including the registered manager, deputy manager, assistant manager, senior care workers, care workers, the cook, house keepers and administration staff.

A third inspector and two assistant inspectors were working remotely reviewing documentation, and telephoning relatives and staff. They spoke with 15 members of staff, 16 relatives and one person who lived at the service .

We reviewed documentation of seven people's care records, medicine administration records and, three 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 also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. They sent us several documents including policies and audits, care plans, risk assessments and Medication Administration Records in relation to another five people. We spoke with two healthcare professionals who regularly visit the service.

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 Good. At this inspection this key question has now deteriorated to Inadequate.

This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

● People were placed at serious risk of acquiring Covid-19 and other infectious diseases. The registered manager, management team and staff consistently failed to use Personal Protective Equipment (PPE) as per the national government guidance. The deputy manager told us use of PPE was only a "recommendation" and so staff compliance was not "forced." This meant people were not safely protected and were unnecessarily exposed to infection risks and associated serious and severe health complications.

Assessing risk, safety monitoring and management

● People's needs and associated risks were not consistently identified or managed. Care plans and risk assessments did not contain enough information required to keep people safe. For example, the care plan of a person at high risk of developing pressure ulcers did not contain any guidance on how to ensure their skin was to be cared for, or how to manage and reduce the risk. This meant people's needs were not safely met.

● Staff did not always follow people's care plans. Three people required two hourly repositioning to help their pressure wounds to heal, and prevent further pressure wounds developing. Repositioning charts showed people were not being repositioned regularly. This meant people were at risk of avoidable harm and neglect.

● People did not always receive appropriate pressure wound care. Visiting nurses were not always confident staff were caring appropriately for some people's pressure wounds. One person had developed an infection which may have been caused by poor infection control and poor hygiene care. This meant people's health needs were not being met safely.

● The service failed to recognise and address people's changing health needs. One person had lost weight and whilst this was noted, there was no immediate action taken to seek advice or intervention from a GP or dietician. Food and fluid records were completed but did not appear to be reviewed. One person did not have enough to drink for four out of seven days which placed the person at risk of dehydration. Action was not always taken when people did not have enough to eat. Staff did not notify healthcare professionals or make attempts to offer alternative food or snacks. This meant people's nutritional and hydration needs were not always met placing them at risk of malnutrition and dehydration.

● The environment was not always safe. People had unrestricted access to areas of the service where they could sustain injuries. Cupboards were unlocked in areas where people living with dementia could access them. One cupboard contained trip hazards and an exposed large pipe which was warm to touch. People could be at risk of burns and injuries if they fell onto or around the exposed pipe and were not able to reposition themselves. Other unlocked cupboards contained cleaning items which could be hazardous to

health. Necessary measures were not in place to keep people safe from the risk of avoidable harm.
● There was not enough equipment available to provide safe care. Each floor had only one hoist, one standing aid and one rotunda irrespective of how many people needed this equipment. People were consequently waiting to receive support with toileting and transfers from bed to communal areas etc. For example, one floor had 12 people who required the use of a hoist to mobilise. A staff member told us the lack of equipment "delays the process of getting people moving." This meant people may not receive the care and support they needed at the right time which may have placed them at risk of harm.

Using medicines safely
● Medicines were not always administered safely. Medication Administration Records (MAR) identified some people missed medicines (such as blood thinning medicine, anti-epileptic medicine and anti-psychotic medicine) for up to seven days at a time. A person told us their relative did not receive medicine for "four to five days" which caused a "hiccup." Some people did not receive time critical medicines. This meant people were unnecessarily exposed to risk of physical and mental health deterioration.
● Medicines were administered against pharmaceutical and NICE guidance. A person was given two medicines crushed and mixed together in a liquid medicine without consulting a pharmacist. How all three medicines worked could have been affected, and people may have been placed at high risk of physical harm due to possible side effects.
● MAR's did not contain reliable or accurate information. For example, some medicines were recorded as a daily medicine, but were also recorded as being an as and when medicine. There was no guidance on where pain relieving patches should be applied to the body. There was no visual guidance on where to apply medicines or topical creams. This meant that staff could not safely administer medicines to people which could have placed them at risk of harm.
● Prescribed creams were not safely administered. MAR's consistently stated that prescribed creams were "not given by the facility." During the inspection, staff (including an assistant manager) told us there were no supplementary paper charts of any kind for people that were filled out. After the inspection the registered manager told us that there were paper records for the administration of creams. To date this evidence has not been seen. There was a high risk that people who required creams to care for and prevent skin breakdown were not receiving this. Risk assessments highlighting dangers associated with flammable creams were also not in place.
● People were not safely administered thickeners. Thickener powders are prescribed for people who have swallowing difficulties. MAR charts were never completed to state that the doses had been administered. There was insufficient guidance in care plans to inform staff practice.
● Medicine audits were completed but were ineffective at identifying areas of concern or errors. This meant that processes could not be put in place to prevent further errors or make improvements.

The provider failed to ensure people were protected from the risk of infection; received care in accordance with care plans and risk assessments; were supported in safe environments with appropriate levels of equipment and received medicines in a safe and appropriate manner. These are all breaches of Regulation 12(1) Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People were not protected from the risk of abuse and improper treatment. Policies were in place, but staff weren't following them consistently. Records showed one person had been physically aggressive and threatening towards people and staff on 10 occasions. The provider had not informed the local authority of these incidents as required to. Risk assessments had not been reviewed following incidents which meant people were being exposed to the continued risk of abuse and avoidable harm.

● Staff understood safeguarding processes and knew concerns needed to be raised with a senior. A staff member told us "If I take a concern to them [seniors/management], 9 times out of ten it will be dealt with but not always." This meant that people may have been exposed to situations which could have resulted in abuse or avoidable harm.
● Nott all staff understood what whistleblowing was. One staff member told us, "You keep things to yourself and confidential and you don't whistle-blow." A lack of understanding could prevent staff from seeking support from external parties such as the CQC if they had concerns about staff conduct and people's care and treatment.
● Staff did not always conduct themselves appropriately. We were informed by some members of staff that other members of staff frequently swore in front of people. One staff member told us "this happened about two to three weeks ago." Another staff member told us that staff swearing in front of people had been an issue but had been addressed. Concerns around alleged staff behaviour were investigated by the registered manager and deputy manager but appropriate action was not taken to sufficiently protect people from further harm.
● Lessons were not learnt. People had left the service unsupervised when they were not safe to do so. Some people were living with dementia and the service was close to a busy road. A recent safeguarding investigation carried out by the local authority identified that people were still at risk of leaving the service unsupervised. Some staff told us people attempting to leave the service was a problem. One staff told us. "Not enough care is taken to ensure that doors are shut especially when deliveries to the service are made." This demonstrates there are ongoing risks, but no actions appear to have been taken to mitigate risks and prevent further incidents from happening.
● The registered manager and deputy manager acknowledged the importance of learning lessons and identified they had worked with the GP practice to implement a weekly meeting to discuss areas of concern, but this did not appear to be an effective approach to learning lessons when things went wrong.

The provider failed to ensure that people were protected from abuse and improper treatment. This is 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.

Staffing and recruitment
● There was not enough staff to meet people's needs or keep them safe. During our inspection a non-care worker was observed assisting people at breakfast as there weren't enough care staff. A staff member told us, "I am rushing, and things get missed. I feel really bad that I cannot give the time and attention that everyone deserves when I am busy." Another staff member identified people do not receive support in a timely manner due to lack of staffing. Staff told us "[people] get their breakfast, but might get it in bed, then we get them up. We try to ensure the majority get into the dining room for lunch." One person's relative agreed "staff are stretched" but commented on how friendly and approachable staff were. 8 other relatives commented on how busy staff were and that more staff were required.

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.

● Recruitment processes were in place. Three staff records were viewed which indicated staff had been recruited safely.

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 Good. At this inspection this key question has now deteriorated to Inadequate.

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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager did not promote an open and positive culture. There was evidence the management and staffing team were complicit in misleading the CQC regarding the use of PPE during inspection. This behaviour did not demonstrate an open, honest and transparent culture raising concerns over how people were cared for.
- The service was not well led. The registered manager and management team did not have oversight of the service. For example, no one could provide a definitive number of how many people were living in the service. They were not clear or certain about how each floor of the service was named and referred to. This could cause confusion to staff and could delay exiting the building, for example if there was a fire. A relative told us the lack of leadership is apparent; "The management, even the seniors, it feels like they have just been put in that position and left."

- Quality assurance processes and systems were not adequate and failed to identify that people were not receiving prescribed medicine regularly or safely; care plans and risk assessments did not provide guidance on how to care for people; people's needs were not being identified or met; people's capacity to make decisions was not being appropriately assessed; safeguarding concerns were not being appropriately identified, reported or managed; staff did not have enough equipment to safely meet people's needs; staff were not wearing PPE and staffing levels were not sufficient. Failure to identify concerns in these areas meant that action was not taken to mitigate the risks that people were exposed to, therefore, opportunities to learn and improve the service were missed.
- Staff did not always feel supported in their roles by managers. One member of staff told us "I go to them [managers] with things I see as important like a deterioration in mental health and get told that it has been dealt with, but don't see evidence." Another staff member told us that they felt supported by "most of the management team, but not all of them."
- We found staff were given tasks to complete outside of their usual roles. For example, management of PPE during the COVID-19 pandemic was delegated to the maintenance team rather than the registered manager. This demonstrates a lack of clarity of roles and responsibilities by the registered manager and staffing team which could lead to people being placed at unnecessary risk of harm.

● Managers and staff did not fully understand or apply the Mental Capacity Act 2005 because people's capacity to make decisions was not always assessed or best interest's decisions were not in place in accordance with legislation. This meant people were at an increased risk of having their human rights infringed and receiving care in a disproportionate way. For example one person had a best interest decision made for them around the use of bedrails, but there was no evidence that staff had followed process to assess their ability to make this specific decision themselves.
● While staff were observed to be caring during interactions with people, understanding around best practice and how to promote people's dignity and choices may have been limited. For example , one of the floors of the service is referred to as the 'dementia' floor'. This does not support people's dignity.
● Relatives told us that staff do not always recognise or understand people's needs, (e.g. when someone is in pain) if people had limited communication. A relative told us "I've had to explain the stages of dementia to staff…it seems specialist training isn't there ." This meant that people's needs may not have been met appropriately.

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
● Quality assurance systems were not robust to evidence that the provider had carried out their duty of candour. For example, where incidents of abuse had occurred but had not been thoroughly investigated .

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were not always involved in the development of the service and their care. A regular residents meeting took place, but it was unclear how people who have more complex health needs or were living with dementia had their voices heard. Some staff felt their views were listened to by management and they were able to implement their ideas. One staff member told us how they proposed the use of a pager system which was introduced quickly to improve the service.
● People were not always consulted and included in the development of their care plans. Some relatives told us they had not seen their family members care plans. Relatives were asked for feedback on their views of the service. One relative told us, "They do a review with me every now and then to see if we are both happy with the care [person] is getting. It feels like it is a tick box exercise."
● Relatives told us they felt able to raise concerns, but these were not always satisfactorily resolved. One person told us "If you want to complain, it just keeps going back to the management and doesn't get escalated. It's not clear what the processes are."
● Managers and staff did not always communicate effectively. Some relatives told us they did not always know what support their relatives were receiving. One person told us, "Staff could be more proactive in telling us things that have happened rather than waiting for us to call up." A daily progress note stated that another relative was unhappy about not being told sooner about the involvement of external professionals. Health and social care professionals identified that communication was not always effective which impacted upon people receiving the care and treatment they required.

Working in partnership with others; Continuous learning and improving care
● The service did not always work collaboratively with partnership agencies. Visiting health professionals told us accurate information was not shared at the right time to prevent people's health needs deteriorating. For example, one person was referred to the district nursing team when their pressure wound was at a grade four rather than having been referred earlier. A grade four pressure wound is very deep and may reach the muscle and bone. This meant people were being exposed to harm and unnecessary suffering.
● The registered manager told us that the working relationship with the GP surgery had broken down.

Difficulties with communication has created a barrier to accessing care and support people need in a safe and timely manner. Following inspection, the registered manager approached the GP surgery to arrange meetings to begin repairing the working relationship to encourage positive collaborative working.

- While there were some attempts to carry out quality assurances, it was unclear what arrangements and actions were identified, and how improvements to the service were made.

People were at risk of harm as systems and processes were either not in place or robust enough to demonstrate safety and risk was effectively managed. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.