Temple Court Kettering

Part One

By Eileen Chubb ©

This care home made the news last week due to being rated inadequate and closed by the CQC. The news featured details of the abysmal care that CQC discovered.

However, this is not the full story, indeed its not even an accurate account and appears to be a case of a CQC press release being taken at face value.

There is only one CQC inspection report available for Temple Court under the **new** provider, Amicura.

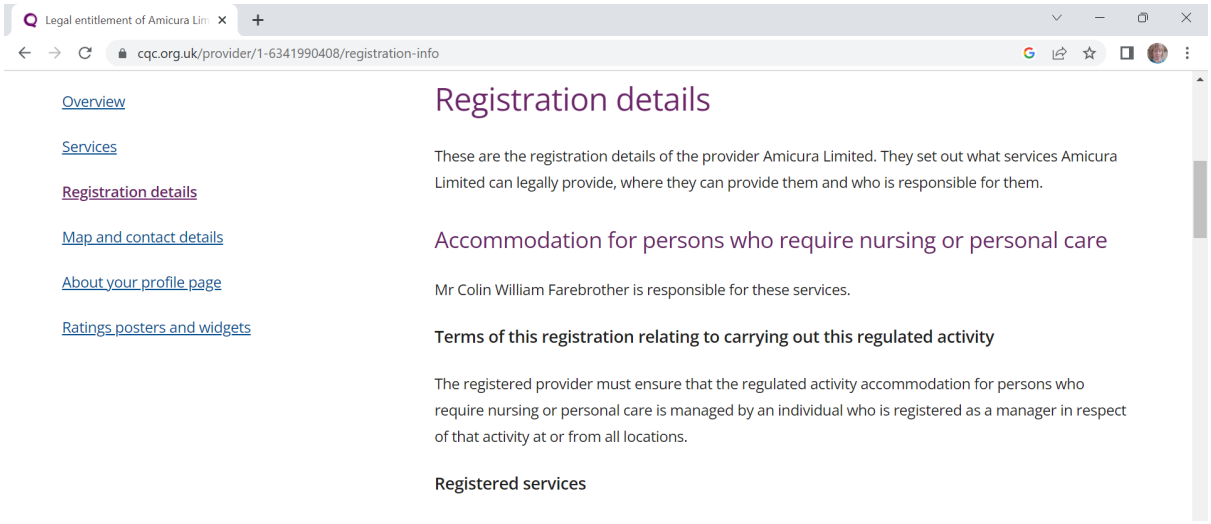
There is an **old** provider listed and only one archive report for that provider, Minster Care.

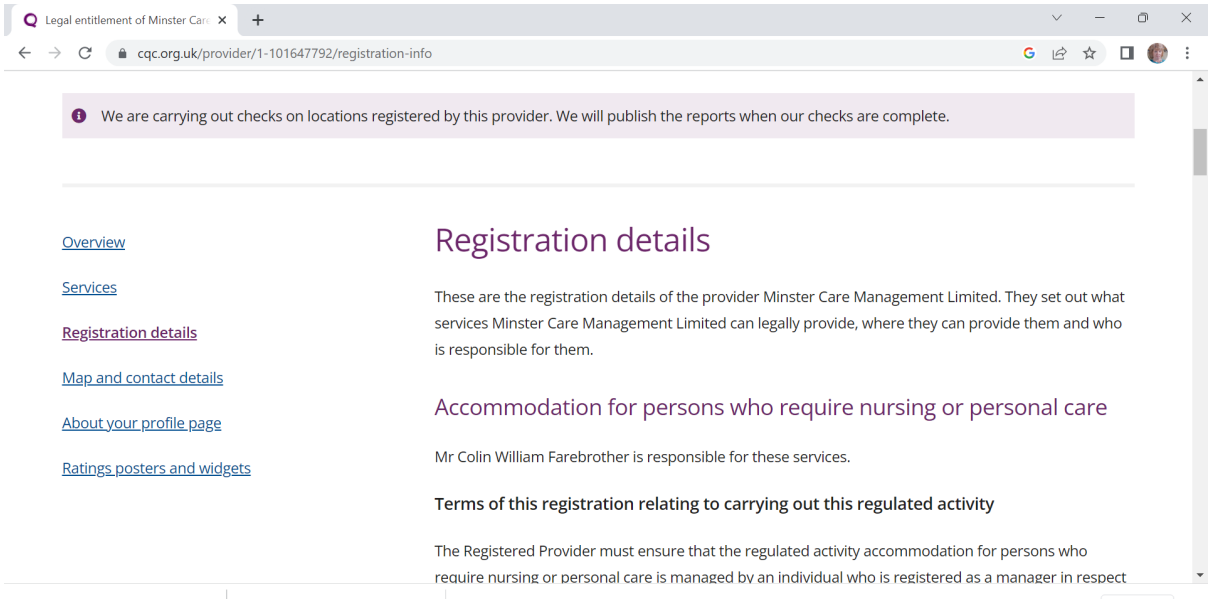
This rings alarm bells for me as only two inspection reports for a care home is odd, especially one that is allegedly inspected for the first time and found to be so bad that it needed to be closed. We have therefore submitted an FOI to CQC asking for any other reports for the location Temple Court.

Many people will recall that it was Compassion in Care who exposed for the very first time that care homes were being registered as new and their history archived, when in fact they were not new at all but owned by the same company. * We are very grateful to the amazing Private Eye, who helped expose this scandal.

Our previous work exposed how reregistering bad homes did not stop that bad culture but gave such homes a clean slate, misleading the public. CQC assured us at the time that no home would be registered in this way unless its last inspection report was good. It’s clear that those assurances were false.

The registration details for the listed new owners of Temple Court,





Mr Colin William Farebrother is responsible for **both** Amicura and the previous listed owner, Minster Care Management.

When the above circumstances occur, I always ask was there any failings in the old inspection reports that could have prevented the future failings had they been acted on?

In this case the answer is yes, " **Minsters**" Temple Court was rated " Requires improvement" in all five areas.

Temple Court inspection report dated **May 2019**

“People's experience of using this service: Quality assurance systems and processes were not effective. They had not identified that risk assessments and care plans had not been completed; non-compliance with health and safety guidance in relation to bedrails; incorrect and missing personal emergency evacuation plans (PEEPS); inconsistencies in the completion of Mental Capacity Act (MCA) documentation; inconsistent recording of people's fluid intake in care records and an inaccurate record of staff training. Risk assessments did not always accurately reflect people's needs. Risks to people becoming trapped in gaps between bed rails, bed frames and their mattresses had not been identified or reduced.
The manager was not aware of all incidents and accidents that had occurred which meant they were unable to ensure appropriate action had been taken to safeguard people.”

“Risk assessments did not always accurately reflect people's needs. We observed one person choke on their breakfast. The person's risk assessment and care plan did not clearly identify the risk of choking. It did not reflect health professional advice or the action that needed to be taken to reduce this risk of choking. This meant staff were not clear how the person's food needed to be prepared, which increased the person's risk of choking. We raised our concerns with the manager, who told us the person's risk assessment and care plan would be updated.
• Risk assessments were regularly reviewed. However, we found risk assessments had not been consistently. completed for the use of bed-rails. Records showed one person had become trapped between their bed-rail causing an injury. The person's risk assessment and care plan were not reviewed following this incident to identify what measures needed to be put in place to reduce the risk of this incident reoccurring.”

“Requires Improvement: People did not always feel well-supported, cared for or treated with dignity and respect.”

“Requires Improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of

high-quality, person-centred care. Some regulations may or may not have been met".

"Quality assurance systems and processes were not effective. They had not identified risk assessments and care plans that had not been completed; non-compliance with health and safety guidance in relation to bed-rails; incorrect and missing PEEPS; inconsistencies in the completion of Mental Capacity Act documentation; inconsistent recording of fluid intake in care records; an inaccurate record of staff training and accident and incident data not being reported to the manager.
• Not all staff were clear about their roles as they were a new staff team. It was unclear whose responsibility it was to check mattresses fitted snuggly between bed-rails and bed frames to reduce the risk of people becoming trapped".

"There had been several changes in the staff team. New staff were still getting to know people. One relative told us, "There are new staff who need to take time to understand the ways of my [relative.]"

"Regular staff meetings took place to share best practice, discuss people's needs and to identify Improvements. Records showed areas of discussion were training, supervisions, infection control. We recommend the provider discuss safeguarding during these meetings. Regular staff meetings took place to share best practice, discuss people's needs and to identify improvements Records showed areas of discussion were training, supervisions, infection control."

"The manager had devised an action plan following quality assurance visits from the local authority and clinical commissioning group. We saw improvements had been made because of these. For example, protocols for as required medicines had been implemented and additional clinical skills training for nurses had been undertaken. However, we could not be assured improvements would be sustained or were embedded in practice."

"The provider failed to keep people safe from unsafe care and treatment.
The enforcement action we took:

We imposed conditions on the provider's registration to provide detailed information and action plans demonstrating how they are ensuring compliance with the regulations."

The are many other areas of concern highlighted but one of the most concerning is a staff member telling inspectors that things had massively improved since the new manager recently came. This indicates that things were very wrong before. I do not have any previous inspection reports but will follow up on this once I receive a response from CQC regarding my FoI.

Temple Court was not inspected again until May 2020 when it was reregistered to Amicura

"Since early April 2020, the registered manager and the senior care team had been absent from the service, the clinical lead was also on prolonged leave. In the absence of the registered manager, senior care team and clinical lead, the provider failed to ensure they had sufficient oversight of the service.
People's risks had not always been assessed or updated regularly as people's needs changed. People's care plans did not always reflect people's current needs. Staff did not have enough information about people's current needs to provide safe care that met their needs.
The provider failed to deploy enough staff with the skills, competencies, and supervision to carry out their roles safely.
Staff had not received all the training they required, or had their competencies checked, to ensure they could meet people's needs.
New, agency and deployed staff did not receive an adequate induction or receive supervision which led to poor care.
People were not protected from the risks of abuse or poor care. Staff did not identify or report where people had come to harm, or report incidents, accidents and unexplained bruising. Following visits by commissioners a number of safeguarding referrals were made for people. People's health deteriorated and was at risk due to the lack of clinical and managerial oversight of their medicines, falls, mobility, wound care, pressure area care, clinical observations and infection prevention

and control. Staff failed to take prompt action to seek medical care where people displayed signs of ill health or failed to receive their medicines. People were identified as being malnourished and dehydrated. People were at risk of malnutrition and dehydration as staff did not provide food and drink that met each person's needs. The provider failed to ensure there was sufficient oversight and monitoring of what people ate and drank or monitor their weights.
Staff failed to identify and refer people to health professionals where people lost weight."

"Why we inspected
We received concerns in relation to people's nursing care needs, health needs, medicines, wound care and nutrition and hydration needs. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. Following the inspection and identified safeguarding concerns a criminal investigation is in progress."

Please note that CQC carry out this inspection only after the harm has been done and they are told about that harm.
Only now do CQC refer to the last inspection but failed to mention that the last inspection report was archived as belonging to an old owner.

Anyone placing a loved one in this home would not have read the last report as its archived. They would not have known there were major problems.

15 people died in this home and CQC prosecuted Amicura, but they had to rely on both inspection reports including the one they archived.

During Covid 15 people were admitted to the home from hospital and CQC said the home failed to ensure it had the capacity, systems, and processes to safely manage the admissions. It led to an outbreak of Covid 19 which affected existing residents and a large proportion of staff.

People suffered and died in horrendous circumstances and our thoughts are with all those affected by this foreseeable and completely avoidable tragedy.

CQC have had to rely on a inspection report they had previously archived in order to prosecute. It’s a shame that families were not given the information in that report.
There also has to be responsibility placed on Matt Hancock and Boris Johnsons Government for their policies which could only result in tens of thousands of avoidable deaths.

Eileen Chubb

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