Glenside Manor Healthcare Services Limited

Newton House

Inspection report

Warminster Road
South Newton
Salisbury
Wiltshire
SP2 0QD

Tel: 01722742066
Website: www.glensidecare.com

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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:
Newton House is a care home providing personal and nursing care to 11 people with progressive neurological conditions. It is one of six adult social care locations and a hospital registered separately with CQC that are on the same site.

Each of the services is registered with CQC separately. This means each service has its own inspection report. The ratings for each service may be different because of the specific needs of the people living in each service. While each of the services are registered separately some of the systems are managed centrally for example maintenance, systems to manage and review accidents and incidents and the systems for ordering and managing medicines. Physiotherapy and occupational staff cover the whole site. Facilities such as the hydrotherapy pool are shared across the whole site.

People's experience of using this service:
People were not safeguarded from abuse and were placed at significant risk of harm.

Following the inspection in March 2019 CQC were informed of two incidents involving the poor management of Percutaneous Endoscopic Gastrostomy (PEG) tubes. These incidents are currently under investigated by the local authority safeguarding team. CQC will consider these incidents under our specific incident guidance.

Despite these incidents during this inspection we found that the needs of people with PEG's continued not to be managed safely. There was little evidence that checks, and management routines were consistently followed.

Following the inspection in March 2019 CQC were informed of two incidents involving poor medicines management. Despite these incidents at this inspection we found that medicines were not safety managed leaving people at significant risk of harm

The service was not well led. The management had not taken action in response to events that had or could cause harm to people. There have been persistent changes of senior managers. There was a lack of regulatory response from the provider.

Rating at last inspection: The overall rating was changed to Inadequate at the focused inspection dated March 2019.

Why we inspected: This inspection was brought forward due to information of risk or concern following the last inspection, in March 2019. After the inspections in August & November 2018 and March 2019 CQC requested assurances from the provider about the action they would take to improve the service. The responses provided by the provider did not give assurances that the service would improve.

Enforcement: Following the last inspection we imposed a condition on the providers registration to submit monthly improvement action plans to CQC. The action plans provided did not give assurances that the service would improve.

Section 31 of the Health and Social Act 2008 allows the Commission to serve a Notice of Decision upon providers if it has reasonable cause to believe that, unless it acts any person will or may be exposed to the risk of harm.

The Commission used its powers pursuant to the urgent procedure (for suspension, or imposition or variation or removal of conditions of registration) under Section 31 of the Health and Social Act 2008. Although the provider told us they intended to close the service we continued to urgently remove the regulated activity from the registration."

Follow up: This service has been placed in special measures. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Newton House

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by notifications of incidents following which people using the service sustained a serious injury.

The information shared with CQC about an incident indicated potential concerns about the management of risk of unsafe medical intervention. Other incidents indicated potential concerns about the management of risk of unsafe Percutaneous Endoscopic Gastrostomy (PEG) management. This inspection examined those risks.

Inspection team:
This inspection was carried out by two inspectors, a specialist advisor, Pharmacist and an assistant inspector.

Service and service type:
Newton House is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 did not have a manager registered with the Care Quality Commission. This means that the registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. There was an interim home manager in post at the time of the Inspection.

Notice of inspection:
The inspection took place on the 30 April and 1 May 2019. The first day of the inspection was unannounced.

What we did:
Before the inspection we assessed the information, we hold about the service. We looked at notifications, previous inspection reports and the information professionals shared with us.

During the inspection we looked at the care records of six people, accidents and incident reports, audits and quality assurance reports.

Inadequate

Is the service safe?

Our findings

We inspected this key question to follow up concerns received since the focused inspection in March 2019. We found continued breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider has consistently failed to comply with this requirement since the comprehensive inspection dated in August 2018.

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse

- People were at risk from avoidable harm. The provider was failing to meet the medical needs of people including those that have their nutritional needs met through percutaneous endoscopic gastrostomy (PEG) tubes. In addition, the provider was failing to reduce the risk of avoidable harm due to the poor management of medicines

- We were notified of an abuse incident by the leadership team at the home and they raised a safeguarding referral to the local authority. We will be following the specific incident procedures.

Assessing risk, safety monitoring and management

- People were at risk from avoidable harm. The safety of people at risk of potential harm was not assessed or monitored. The medical needs of people with PEG nutritional feeding tubes were not met by the staff. The unit manager said the procedures were taking place although records did not support this.

- The training records showed that not all staff undertaking PEG changes were competent to carry out this procedure.

- Care plans were not clear or coordinated for people whose nutrition was through PEG feeding tubes. Records did not show guidance from healthcare professional such as dieticians was followed. For two people the dietician gave guidance on 24/4/19 for the PEG tube to be changed within seven days. However, there was no evidence the PEG tube was changed. We noted a replacement tube was not available for the change to take place within the timescale. This meant the provider could not be assured that healthcare professional guidance was followed.

- There was no evidence that guidance to change PEG tubes were followed. Care plans to meet nutritional needs of people with PEG feeding tube gave instructions on when staff were to change the PEG. The records of changes did not show when this was done consistently. For example, the instructions to staff for one person was to change the PEG tube four monthly. The most recent change occurred in 20 February 2018. However, there were no previous records of when the PEG's were changed. This meant PEG changes were not monitored.

•□Management regimes for PEG were not consistently followed by the staff. There was limited evidence that PEG tubes were rotated. The care plan for one person gave staff instruction to rotate and check the inflation of the PEG weekly. Although inflation checks were consistently recorded for January, February and March 2019 the records were missing for April 2019. The registered nurse on duty confirmed this information was the only record of these checks and agreed it was poor recording. For another person the care plan stated the PEG should be advanced and rotated but did not give any frequency for this. The recording sheet stated it should be advanced, but not rotated, once a week. Newton House used agency nurses to cover the majority of day time shifts. The inconsistency in the guidance increased the risk that care of the PEG would not be completed safety

•□There was no evidence the PEG was rotated in February and in March 2019.

•□People were at risk of dehydration. For people with PEG's the dietician had formulated a plan of fluids to be given by staff. The fluid charts we reviewed did not confirm that the fluids had been given in line with the plan. For example, on one day for one person the plan was for the person to receive 2075ml however when we added the fluid chart they had received 1825ml. For other people the records of fluids taken was only kept intermittently

•□Guidance was for staff to check people's weight weekly. A records of people's weekly weights was not consistently documented. These weights would be used by other professionals to ensure that people were receiving the correct nutrition through their PEG tubes. Due to the lack of weight recording it not be confirmed if people had lost weight.

•□At the comprehensive inspection dated August 2018 we required the provider to have systems that ensured air mattresses were set correctly. However, for one person at high risk of pressure damage the care plan did not list the setting for the pressure relieving mattress. We observed on the day of the inspection that the pressure mattress was not on the correct setting in line with the care plan. Due to this the person was at increased risk of developing pressure ulceration

•□Equipment reported to be used for minimising the risk of falls was not used. For one person the summary of needs dated 29 April 2019 lacked information on specific risk that was referenced in the mobility care plan. The mobility care plan and risk assessment in place, stated a crash mat must be positioned in front of their wheel chair due to the risk of falling. On the second day of the inspection, no crash mat was in place. This left the person at risk of injury due if they fell. We informed the unit manager of our observations.

The findings of this inspection show a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

•□We observed the administration of medicines during inspection for two people. Glenside's 'guidelines for the management of enterally fed patients' states that 'patients must be at 45 degrees or above during feeding'. One of the two people was administered medicines while lying down which increases the risk of vomiting and aspiration. This left the person at significant risk of harm

•□ The nurse who administered the medicines for these two people did not flush the PEG in between each medicine. This increase the risk of a drug interaction and the PEG becoming blocked.

•□Care plans lacked detail on how medicines should be administered and there was no record of

pharmacist involvement. Administering medicines down a PEG without the correct advice, may increase the risk of the tube becoming blocked, which would mean an unnecessary invasive procedure to replace the tube.

•□The service used agency registered nurses for the majority of the day shifts. There was no record of competency assessments for agency staff to give medication through the PEG

•□There were missing signatures on the Medicine Administration Record (MAR) charts with evidence of the medicine not being given. This included medicines for pain relief; Parkinson disease and to reduce muscle spasm. Due to this we could not confirm that people were receiving their medicines as prescribed. The lack of medicines administration as prescribed could have left people in pain and discomfort.

•□Some people used patches for the relief of pain. The body maps that were in place lacked the detail on the exact place a pain patch was applied. This is required to avoid variability in drug absorption

•□One person was on time specific medication to ease their symptoms of Parkinson's disease. This was due to be given at 12:00 midday. We observed that on one day of the inspection this had still not been administered by 13:30. If a person with Parkinson's disease does not receive their medication on time, it can cause loss of symptom control and it may take a long time to recover.

The findings of this inspection show a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

We inspected this key question to follow up concerns received since the focus inspection in March 2019. We found continued breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider has consistently failed to comply with this requirement since the comprehensive inspection dated in August 2018.

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

Inadequate:There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

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

•At last comprehensive inspection completed on 29 and 30 August 2018 and at subsequent focussed inspections on the 7 November 2018 and 13 March 2019 we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following all the inspections, we asked the provider to tell us how they were going to meet Regulations. The provider failed to report on the actions to meet Health and Social Care Act 2008, its associated regulations, or any other relevant legislation on how regulations were to be met.

•Following the previous inspections, we took enforcement actions. We imposed conditions on the providers registration (part of our enforcement pathway). These conditions required the provider to submit monthly actions plans to CQC from the February 2019. These action plans were not received until after the inspection in March 2019. The action plan received after the inspection in March 2019 did not provide adequate assurances detailing how the service was going to improve.

•Following each of the inspections we met with the provider. At these meetings the provider gave assurances that improvements would be implemented and that an action plan would be submitted. At this inspection we found that the improvements had not been implemented in line with these assurances.

• Following the inspection on the 13 March 2019 CQC were informed of two incidents that caused harm to two people due to poor management of PEG's. We also received two incidents relating to poor medicines management. Despite these concerns the provider had not taken action to review or implement improvements with PEG or medicines management

•A registered manager was not in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was in the process of

deregistering and a home manager had been appointed.

•□There was a lack of communication and oversight between the provider and senior management at the Glenside site. The senior management team had not been not stable at Glenside since October 2018. Some staff felt there had been too many changes in management and they weren't clear who they could go to and who they could trust.

•□Following the focus inspection dated 13 March 2019 we were told that the new CEO had left employment at Glenside. This follows the dismissal or resignation of the previous senior management team during November 2018 and the subsequent deregistration of all registered managers for ASC locations. All the ASC locations were being managed by unregistered managers. This turnover of senior management has adversely affected the stability of the service and the implementation of the improvements that are required.

•□Full information about CQC's regulatory response to the more serious concerns found during this inspections will be added to the report after any representations and appeals have been concluded.

•□We have been working in partnership with external agencies including Clinical Commissioning groups (CCG's) and Local Authorities who purchase care for the people who live at Glenside. We were told that the CCG and Local Authority had sought assurances from the provider in the form of contract monitoring meetings and subsequent requests of an action plan. These action plans were to detail how the provider was to improve the service delivery. Action plans have not been submitted despite repeated requests from the CCG. When an action plan was submitted it did not robustly detail the action that were going to be taken to improve the care that was being delivered

•□Following the inspection, we fed back our findings to the CCG's and Local Authorities who purchase care for the people who live at Glenside. In response to the ongoing concerns and risk to people health safety and wellbeing the funding CCG's told us that they were reviewing the care needs of people across the whole site. In response to these reviews and to the pending CQC enforcement action alternative placements were being sought for all people. CQC continue to work with other agencies to ensure the safety of people

•□Following the inspection, we were contacted by a firm of administrators. The administrators told us that they had taken the over the running of the company and new directors had been appointed. The directors told us that they had reviewed all the issues at the services and had made the decision to close all locations registered at "Glenside"

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	There were failures to prevent avoidable harm or risk of harm which is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

There were failures to prevent avoidable harm or risk of harm which is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	There were failures to ensure the effectiveness of quality assurance systems. Systems and processed that protect people were not in place. Audits were not robust and action plans were developed to improve the quality and safety of the services provided. This is a continued breach

The enforcement action we took:

There were failures to ensure the effectiveness of quality assurance systems. Systems and processed that protect people were not in place. Audits were not robust and action plans were developed to improve the quality and safety of the services provided. This is a continued breach