Glenside Manor Healthcare Services Limited

Langford/Kennet

Inspection report

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Date of inspection visit:
07 November 2018

Date of publication:
12 April 2019

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We undertook an unannounced focused inspection of Langford and Kennet on 7 November 2018. After the comprehensive inspection dated 11 and 12 July 2018 we received concerns in relation to staff not having appropriate checks before starting employment, language barriers of staff, poor working and living conditions for staff working as agency staff, competency of staff undertaking maintenance checks and lack of equipment across the Glenside Manor site. As a result, we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those concerns. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Langford and Kennett on our website at www.cqc.org.uk.

The team inspected the service against two of the five questions we ask about services: is the service well led and safe. This is because the service was not meeting some legal requirements.

No risks, concerns or significant improvement were identified in the remaining Effective, Caring and Responsive through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

Langford and Kennett provide nursing care for up to 16 adults with progressive neurological conditions. Langford and Kennett is one of six adult social care locations at Glenside which also has a hospital that is registered separately with CQC. The location of Glenside Manor Healthcare Services is not close to facilities and people may find community links difficult to maintain. 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.

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.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission 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.

At the previous inspection dated 11 and 12 July 2018 we found breaches of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider following the inspection to tell us how they were going to meet Regulation 12 and 17. 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 At this focused inspection we found continued breaches of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The CQC following the inspection formally requested under Section 64 of the Health and Social Care Act 2008 to be provided with specified information and documentation by 16 November 2018. We received some of the information requested but not all.

Quality assurance systems were inadequate. Audits were not robust and did not provide an accurate assessment of the quality of care delivered. Action plans were not developed to drive improvements. The CQC was not notified of accidents and incidents reportable under the Care Quality Commission (Registration) Regulations 2009: Regulation 18.

The CQC received whistleblowing concerns about staff not being able to speak sufficient English. These staff were referred to as "agency staff" and were working without appropriate checks. We found there were some staff working across the site without the appropriate disclosure and barring checks or references in place. A whistleblower told us during the inspection that one staff had been working at the home without disclosure and barring checks. Relatives also expressed concerns about staff not able to speak or understand English.

Recruitment procedures did not ensure the staff employed at the home were suitable to work with vulnerable adults. There were staff employed through a recruitment agency and referred to as "agency staff" because of their terms and conditions. The HR assistant was not able to show that agency staff recruited were suitable to work with adults at risk.

New staff did not always have an induction to prepare them for the role they were employed to carry out. We were not able to verify that new staff had an appropriate induction before starting work. We were informed that not all staff had received an induction or mandatory training due to the level of the English they spoke and understood. Staff responsible for training were not able to sign new staff as competent due to their English speaking skills being poor.

The staff were not trained to deliver care to people that were fully ventilated or with tracheostomies. The training matrix provided under Section 64 of the Health and Social Care Act 2008 listed that 75 percent of staff had attended tracheostomy training and ventilator training was not attended by staff. Whistleblowers told us the training was not adequate and did not provide them with the confidence needed to deliver safe care and treatment. A relative told us about their concern with staff not having sufficient understanding of English to deliver adequate care to people.

Whistleblowers told us senior managers were unaware of staff working and accommodated within Glenside Manor. We received concerns about staff known as "agency staff" as they were not directly employed by the provider but introduced to the provider by recruitment agencies. There were a number of staff on site whose identity could not be confirmed by the most senior staff on duty. The list of agency staff provided on the first day of the inspection was not up to date as we met another 11 agency staff during our inspection that were not on the list.

The CQC received whistleblowing concerns about the competency of the staff undertaking maintenance checks of systems and equipment. The CQC following the inspection requested proof of the competency of these staff from the provider. The documentation provided under Section 64 of the Health and Social Care Act 2008did not give CQC reassurances that staff undertaking maintenance checks were skilled or competent.

The information received from relatives about raising concerns was not consistent with the complaints log.

Staff morale was poor and staff told us they feared about their jobs as they had witnessed other staff being dismissed almost daily. The staff survey provided under Section 64 of the Health and Social Care Act 2008 indicated that 13 of the 38 staff responding would recommend the home.

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. This means that it has been placed into 'Special measures' by CQC. 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.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Some staff were not trained to meet the needs of people.

Recruitment was not managed safely and staff were working across the site without appropriate checks.

There was insufficient equipment for transfers.

Repairs of the property were not undertaken by staff that had the qualifications or specific skills.

Is the service well-led?

Inadequate

The service was not well led.

The quality assurance systems in place were not effective. Audits were not robust and did not assess all areas of service delivery. Action plans were not developed on driving improvements.

CQC were not notified about incident and accidents of events reportable by legislation.

Staff morale was poor and they were fearful for their jobs.

Langford/Kennet

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, 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 by whistleblowing concerns. These involved staff not having appropriate checks before starting employment, language barriers of staff, poor working and living conditions for staff working as agency staff, competency of staff undertaking maintenance checks and lack of equipment across the Glenside Manor site.

Information of concern was shared and consultations were held with CQC colleagues in the hospital directorate, Wiltshire Council Safeguarding and Commissioning and Clinical Commissioning Group (CCG). Associated agencies that that have regulatory powers for the safety of the premises and staff were made aware of concerns.

This inspection took place on 7 November 2018 and was unannounced.
The inspection was carried out by two inspectors.

We observed people with staff in communal areas. We spoke with the registered manger, deputy manager, registered managers from other locations and rehabilitation assistants including senior rehabilitations assistants. We also spoke with the office manager, quality and safety lead, HR assistant, maintenance staff, night manager, catering staff and chef.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection dated 11 and 12 July 2018 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 . We found medicines systems were not safe. We found gaps in the recording of medicine administered. There were errors with the medicines supplied and some were out of stock. There was a lack of clear guidance on administering "when required" (PRN) medicines. We asked the provider following the inspection to tell us how they were going to meet this regulation. Following the inspection, the provider failed to provide us with an action plan to tell us how they were going to improve and by when. At this focused inspection we found other parts of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were not being met.

The CQC formally requested under Section 64 of the Health and Social Care Act 2008 following the inspection to be provided with specified information and documentation by 16 November 2018. We found gaps in the information received.

Recruitment procedures did not ensure the staff employed at the home were suitable to work with vulnerable adults. Before the inspection the CQC received Whistleblowing concerns that staff were working at Glenside Manor without appropriate checks. There were staff employed through a recruitment agency and referred to as "agency staff". These "agency staff" were introduced to the provider by recruitment agencies but not directly employed by Glenside Manor Healthcare Services Limited. The HR assistant was not able to show that "agency staff" recruited were suitable to work with adults at risk.

The five staff files we checked did not have satisfactory evidence of previous employment or the qualifications and skills in caring as required by Regulation 4 Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. We found the recruitment agency provided the written references which meant satisfactory evidence of conduct from the previous employer was not provided.

There were agency staff working across the site including Langford and Kennett without the appropriate disclosure and barring checks. Disclosure and barring service (DBS) checks makes sure unsuitable staff were not employed to work with adults at risk. Records of DBS checks were not available at the time of the inspection for all "agency staff" working across locations. On the 7 November 2018 a member of staff showed us a blank risk assessment to be completed for an agency staff that had been working at the home without a DBS check.

Relatives also expressed concerns about staff not able to speak or understand English. A relative told us about their concerns in relation to agency staff working one to one with their family member. We were provided with an example when a registered nurse gave an agency staff instruction to carry out a simple task. The agency staff was unable to complete the task because they were unable to comprehend the instructions. This relative became concerned because this agency staff provided one to one support to their family member who had complex needs.

There had been a significant turnover of staff in the last 12 months and some staff confided they were

unhappy and were considering alternative employment. The HR assistant told us 240 staff across the Glenside Manor and hospital had left since 2017. There was an expectation from the provider to use "agency staff" to maintain staffing levels. The minutes of the managers meeting dated 18 September detailed that staff were leaving across the Glenside Manor site. For example, at the home one rehabilitation assistant and one registered nurse had resigned. Also detailed was that two other resignations were expected from two senior registered nurses who were seeking better terms and conditions.

New staff did not always have an induction to prepare them for the role they were employed to perform. The training matrix provided under Section 64 of the Health and Social Care Act 2008 showed new staff did not complete the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. While the training matrix indicated 96 % compliance with training there were seven names included in the staff list that were not on the training matrix. There was no evidence of the training attended by seven staff included in the staff list but not on the training matrix.

There was an internal induction programme of topics and once complete staff were signed off as competent. The training matrix provided during the inspection showed five staff were undertaking this induction. However, there was no evidence in the five staff files we checked of the induction completed or in progress. We were informed that not all staff had received an induction or mandatory training due to the level of the English they spoke and understood. It was said that the training staff would be unable to sign these staff off as their English was so poor.

There were registered nurses that were not trained to carry out checks and tests of equipment for people that were fully ventilated or with tracheostomy. Whistleblowers raised concerns during the inspection about the quality of ventilator and tracheostomy training. Whistleblowers told us ventilator training provided in September 2018 was cancelled midway because it was not appropriate. Whistleblowers said the training did not give them the confidence to undertake checks or provide support when they were assigned one to one with people that were fully ventilated. A whistleblower told us the training was outdated and consisted of slides and handouts only. A relative told us the agency staff had a poor understanding of English and were not trained or skilled to maintain their family members airway clear.

The training matrix provided under Section 64 of the Health and Social Care Act 2008 included the names of 9 registered nurses including the registered manager. One registered nurse in 2015 had attended Advanced Respiratory life support including Tracheostomy and Ventilator training. Ventilator training was attended by three staff in 2015, 2016 and 2017. This meant three registered nurses had not attended annual ventilator training but nine had not attended this training. Eight staff including the registered manager had attended tracheostomy training in 2018 and three registered nurses had attended the training in 2015 and 2016.

Whistleblowers raised concern that qualified staff were not always on duty to carry out specific medical procedures. Registered nurses from the hospital unit were then asked to carry out these medical procedures. A whistleblower told us "we don't get appropriate training, especially for the [name]". Training is not adequate." We invited the provider to feedback about our concerns and to gain reassurances of improvements in the delivery of care people were to receive.

During our inspection we noted the integrity of a bedroom door was compromised. This person would need the support of the staff to leave the bedroom in the event of a fire and oxygen was also kept in this bedroom. The staff we spoke with also told us the front door was not closing fully which. Staff told us the repair was reported repeatedly. We referred staff's concerns to the fire safety authorities.

The CQC was not informed of two incidents where staff failed to respond appropriately to ventilator alarms. Although we were reassured that other registered nurses responded to the emergency bell we raised a safeguarding alert and CCG reviewed the care of this person. The CQC will consider these incidents under specific incidents regulations 2015.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whislteblowers told us following the inspection that a physiotherapist had gone to the home to change a tracheostomy tube. The physiotherapist told the staff they were acting on the providers instructions. The staff refused to allow the physiotherapist to change the tracheostomy tubing. We passed this information to the Clinical Commissioning Group (CCG) who insisted that only qualified staff undertake tracheostomy care.

Inadequate

Is the service well-led?

Our findings

At the previous inspection dated 11 and 12 July 2018 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that quality assurance and audit systems were not robust and did not cover all areas of care delivery. We asked the provider following the inspection to tell us how they were going to meet the Regulation. The provider failed to provide us with a report of their actions. Following the inspection, the provider failed to report on the actions to meet Regulation 12 and 17 of Health and Social Care Act 2008, its associated regulations, or any other relevant legislation. At this focused inspection we found there was a continued breach of Regulation 17.

The CQC following the inspection formally requested under Section 64 of the Health and Social Care Act 2008 to be provided with specified information and documentation by 16 November 2018. These documents included audits that measured the quality of service delivery. We also invited the provider to feedback about our concerns and to gain reassurances of improvements in the delivery of care people were to receive.

Quality assurance systems were inadequate and there was little evidence that improvements were prioritised. Copies of audits received were not based on the quality of the care delivered but that records were in place. For example, audits demonstrated 100 percent compliance for health monitoring, medicine administration records (MAR), medicine management, equipment and for personal protective equipment (PPE). Care plan reviews assessed that people had care plan in place for such needs as personal care, communication and mobility. However, the quality of the care plans was not assessed. We were not provided with infection control audits.

The staff did not feel valued and their rights and wellbeing were not protected. We received whistleblowing concerns about the leadership of the organisation. On the first day of the inspection we were told there were no senior staff on duty. The staff we spoke with were distressed about an incident that has occurred the previous day, between the provider and senior managers. The staff told us morale was poor across the six locations as they were in daily fear of losing their jobs, due to witnessing other staff being dismissed daily and subsequently ordered off site. The annual staff survey results provided by the operation's director indicated 50% of staff felt the organisation did not take positive action about their health and wellbeing.

Staff told us that they felt there was a bullying culture at the service and would not be able to raise concerns. The staff told us morale was poor across all locations as they were in daily fear of losing their jobs, due to witnessing other staff being dismissed daily and subsequently ordered off site. We have been made aware that a number of staff did not feel that their employment rights have been protected.

The provider was not able to demonstrate that staff working at the home were suitable to work with vulnerable adults. During the inspection staff told us there were language barriers, staff were working without appropriate clearances and were not trained to meet people's care. The HR assistant was not able to verify how many staff were working at Glenside Manor or about the clearance checks of all staff known as "agency staff" working across locations.

The provider failed to ensure there were sufficient staff to deliver continuity of care and agency staff were used to maintain staffing levels. The managers meeting minutes dated 18 September 2018 listed the staff that were leaving and agency staff were being used in all Glenside Manor locations. For example, there was one rehabilitation assistant and one registered nurse that had resigned. Also detailed was that "two senior nurses are looking at handing in their notice." For another location it was stated that "seven staff have left since May 2018."

There were a number of staff on site whose identity could not be confirmed by the most senior staff on duty. We received concerns about staff known as "agency staff" as they were not directly employed by the provider but introduced to the provider by recruitment agencies. Whistleblowers told us senior managers were unaware of staff working and accommodated within Glenside Manor. On the 7 November 2018 we requested a list of all "agency staff" working across Glenside Manor locations. The list of "agency staff" included 30 names. During the inspection CQC inspectors introduced themselves to another 11 "agency staff" which were added to this list. These staff were employed to cover various roles within the Glenside Manor site.

Some "agency staff" were also accommodated within the Glenside Manor site. The provider following the inspection was formally requested under Section 64 of the Health and Social Care Act 2008 to submit a staffing list of staff working across the Glenside Manor locations. The names of 41 "agency staff" were not included in this staffing list or in the training matrix. The minutes of 16 October 2018 meetings also requested by CQC under Section 64 of the Health and Social Care Act 2008 confirmed there was confusion about the personnel living at the Glenside Manor site. The minutes stated that the operation director had requested from the provider "an updated list of staff that live on site, who they are, where they are from and when they arrived."

The provider did not ensure that staff were trained and skilled to meet people's needs. People were placed at risk relating to the health, safety and welfare because staff were not appropriately trained. The provider failed to ensure the staff were trained and competent to meet people's specific needs. For example, tracheostomy and ventilator training.

The maintenance of equipment was not managed safely and placed people at risk of harm. Whistleblowers raised concerns about the competency of maintenance staff working and accommodated at Glenside Manor. Maintenance staff were not qualified to undertake the refurbishments, tests and checks they had been undertaking. The maintenance staff were also undertaking checks of fire alarm system, boiler checks and legionella. We formally requested proof of competence or qualifications for maintenance staff to undertake maintenance checks. However, the various ID cards provided did not demonstrate the competence of the maintenance staff. For example, the provider gave us details of the maintenance manager's Construction Skills Certificate Scheme (CSCS) card. This card provided proof of training and qualification for work they were skilled to undertake in a construction site. (The maintenance manager had a CSCS card for construction site operative.) This meant the maintenance manager qualification was for working in a construction site and only to support skilled staff.

We spoke to the maintenance manager on the 7 November 2018 about their competence and were not able to verify their qualification for water safety. This was because the certificate number on the ID card had faded. Due to this we have been unable to confirm that checks have been completed safely. We have referred these issues to a number of other agencies including the fire department.

We formally requested under Section 64 of the Health and Social Care Act 2008 to be provided with specified information and documentation by 16 November 2018. Documents requested included checks of the

Hydrotherapy pool and gas safety checks. The risk assessment for the hydrotherapy pool was not reviewed annually and was last reviewed in 2016. This was despite a chemical incident, in March 2018, during which the police and the fire department were called. The certificates for gas safety checks provided related to catering equipment and not for the gas heating system at Glenside Manor.

People and others were not protected from the risk of harm. The CQC requested reports of incidents and accidents. Whistleblowers told us on the 7 November 2018, the online reporting system known as GEMS was not being monitored because the staff were not assigned to review online reporting of accidents and incidents. We formally requested under Section 64 of the Health and Social Care Act 2008 to be provided with specified information and documentation by 16 November 2018. Documents requested included reporting of accidents and incidents. This was confirmed by the minutes of the managers meetings dated 2 October 2018 provided under Section 64. It was stated that "Managers are not receiving action updates from GEMs now that [name] has left. Currently nobody is reviewing GEMs."

The provider had notified the CQC of some incidents reportable under the Care Quality Commission (Registration) Regulations 2009: Regulation 18. However, not all incidents were reported. The provider failed to report an incident where fire safety services were called to the Glenside Manor site. We were given access to the online reporting of incidents and accidents on the 7 November 2018 and we noted there was a report of equipment failures. However, this incident related to staff not responding immediately to emergency alarms of equipment and reportable under Regulation 18 of Care Quality Commission (Registration) Regulations 2009. Other incidents not reported included theft and medicine errors.

CQC was told by a whistleblower that staff received lots of complaints and the provider would meet with the families concerned. This whistleblower said complaints "would disappear", so they were not being recorded or dealt with properly. Two relatives told us they had made numerous complaints about the care their family members received. These complaints were not documented in the copies complaints log received under section 64 requests. The feedback from one relative related to their family member when they were accommodated at the home. The other relative's comments related to another Glenside location which focused on the lack of rehabilitation therapies that were promised. Both relatives told us they had received acknowledgement letters to their concerns but there was no further action from the provider. This applies to Langford and Kennett because it was the providers decision to only accept written complaints.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 17 HSCA RA Regulations 2014 Good governance Quality assurance systems The provider failed to ensure safe recruitment procedures were in place The provider failed to ensure staff were trained and maintenance staff were qualified for the repairs and system checks they were undertaking. The provider failed to report allegations of abuse and incidents of potential harm The provider failed to inform CQC of events that prevented the smooth running of the home.

The enforcement action we took:

Impose Conditions