Glenside Manor Healthcare Services Limited

Pembroke Lodge

Inspection report

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Tel: 01722742066

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30 January 2019

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08 March 2019

Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

About the service:

Glenside Manor Healthcare consists of six adult social care services and a hospital all situated in the same complex. Pembroke Lodge is registered to provide accommodation and personal care for up to 16 people with neurological conditions, including acquired brain injury and neurological disorders. At the time of the inspection three people were living at the home.

People's experience of using this service:

- The quality of care people received had significantly deteriorated since the last inspection.
- People had been placed at risk of avoidable harm because heating systems were not operating efficiently, the heating was supplemented by mobile heaters and there was no hot water at times.
- People's care and treatment was being delivered by agency staff that did not know their preferences and how they liked their care delivered.

Rating at last inspection:
This service was rated inadequate published on 05 February 2019

Why we inspected:

This inspection was conducted in response to whistleblowing concerns in relation to the heating not working efficiently and at times a lack of hot water. We also received concerns about poor staffing levels.

Enforcement:

Following the focused inspection we wrote a letter of intent to the provider. We told the provider that "The Commission was considering whether to use 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." The provider responded by providing alternative accommodation to people living in Pembroke Lodge.

Follow up:

At the last inspection on 7 and 15 November 2018 the service was rated Inadequate and placed into special measures. We asked the provider to take action to make improvements. We issued warning notices on safeguarding, care and treatment and for staffing. We also imposed conditions on the service. Other enforcement actions taken in relation to Pembroke Lodge were subject to representations.

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. We will have contact with the provider and registered manager following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

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

Pembroke Lodge

Detailed findings

Background to this 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 by whistleblowing concerns regarding the heating and staffing. The service was inspected against one of the five questions we ask about services: is the service safe. This is because the concerns suggested the service was not meeting some legal requirements.

No imminent risks, concerns or significant improvements were identified in the remaining Effective, Caring, Responsive and Well Led 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.

Inspection team:

This inspection was carried out by one inspector.

Service and service type:

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.

Notice of inspection:

This inspection was carried out on the 30 January 2019 and was unannounced.

What we did:

This inspection included speaking to one person, a registered nurse, two agency staff, one locum staff and a member of staff from the hospital team. We also spoke with the operations director, clinical lead and maintenance staff.

We reviewed records related to the care of three people. We looked at records of care plans, daily report, faults reporting and staffing rotas. Records relating to the safety and suitability of the service were reviewed. We looked around the property.

Inadequate

Is the service safe?

Our findings

At the last inspection on 7 and 15 November 2018 significant concerns regarding the safe care and treatment of people were identified. We asked the provider to take action to make improvements. We issued warning notices for safeguarding, care and treatment and for staffing. We also imposed conditions on the service. Other enforcement action taken in relation to Pembroke Lodge were subject to representations.

We have inspected this key question to follow up the concerns found during our previous inspection and in relation to whistleblowing concerns received. We have judged that the rating remains Inadequate.

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

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

Despite being told on the 5 December 2018 that the heating had been repaired we received whistleblowing concerns on the 25 and 28 January 2019 that the heating was not working and there was no hot water. Concerns were also raised that staffing levels were maintained solely with agency staff.

We contacted the operations director regarding the heating who told us the actions to be taken while the heating was not operating effectively. A focussed inspection was conducted on 30 January 2019 in order to ensure that the actions identified by the operations director were appropriate and that they were taking place. At the time of the inspection the temperatures were forecasted to fall putting people at further risk.

Assessing risk, safety monitoring and management:

•□One person told us "sometimes it's cold in the building I can't have a bath I have to use the shower". This person told us the staff used kettles of hot water to deliver personal care in the morning.

•□Records showed people were not always able to have a bath as requested because there was no hot water. Difficult behaviours increased for one person when they were not able to have a bath at their preferred times. The staff recorded on the 17 January 2019 in the inter disciplinary records for this person. "[Name] was waiting on the water to heat up for bath this morning." On the 25 January 2019 staff wrote in the daily notes. "[Name] asked for a bath. It was explained that the boiler is not working so there is no hot water. Asked [Name] if he would like to get dressed. He said "yes". This meant the person was unable to wash as they preferred and got dressed without personal care.

•□On the 29 October 2018 the boiler broke down, at the time of our inspection the heating system had not been fully repaired despite faults being reported.. We saw17 faults reporting from 25 October 2018 until 28 January 2018 were made by staff about the heating and hot water. On the 21 November 2019 staff wrote to the maintenance staff and provider "The heating engineer has been this evening and has said he is not able

to repair the system until he has the new part. This will not be until late tomorrow at the earliest. This means Pembroke Lodge will have been without hot water and heating for at least 48 hours. This is absolutely unacceptable. Some contingency action must be taken to support and protect the people we support." However, there was no response from the provider or senior managers to this email.

• Despite possible damage to the heating system the boiler was being re-set manually. At this inspection a member of the maintenance team arrived to switch the boiler on. Staff were manually resetting the heating system to ensure the building was warm and there was hot water. On the 27 December 2018 staff wrote "To be honest [name] and I have been going in and restarting the boiler ourselves [as it] switch themselves off every 30 mins. or so. So, to answer the question. It has not been fixed." At the manager meeting dated 30 October 2018 the health and safety manager raised concerns to the team about re-starting the boiler. It was minuted that the health and safety compliance manager had "raised the issue with the boiler this morning to the maintenance manager. Following last night's incident (where the heating had broken down) it is important that you do not keep resetting them as this can cause more damage. [Maintenance manager] has said that he does not want to get anyone in until the summer because the system will need to be shut down". This meant there were a numbers of risks, that people would be cold and have no hot water and that damage would be caused to the heating system by staff manually re setting the system. There was no management of either of these risks and no plan in place to mitigate the risk to people.

• The operations manager told us on the 29 January 2019 that the part needed to repair the boiler had arrived and that the boiler was fixed on that day. However, at this inspection we found that the temperature of the building was supplemented with mobile heaters. We checked the heating system twice and on both occasions the boilers were operating. However, not all radiators were working and others were just warm. The radiators in the lounge, bathroom, corridors, the office and staff room were not working. There was no hot water in some hand washing basins. Despite assurances that the boiler had been fixed, the heating and hot water system was not operating effectively.

• The heating system had not been serviced to ensure it was functioning efficiently. The operations director provided copies of boiler certificates and during the inspection we contacted the contractor to validate these certificates. The contractor said the serial number of the certificate should match the serial number with the boiler. We checked this and they did not match. There was no evidence that the boiler had been checked.

• Our concerns were significant enough for us to consider enforcement action. We wrote the provider asking them to report back to us what they were going to do to mitigate the risk associated with a lack of hot water and heating. The provider responded by providing alternative accommodation to people living in Pembroke Lodge. An external contractor visited following our inspection and gave the provider recommendations on the repairs needed to ensure the heating system was operating efficiently.

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The above concerns demonstrated a failure to prevent avoidable harm or risk of harm which was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment:

• We received concerns on the 28 January that staffing levels were made up of agency staff and people were "vulnerable and at high risk." This comments raised concerns that people did not received continuity

of care from staff that knew them.

•□During the inspection one person requested to speak with us. This person told us "the staff that knew how to care" for him were no longer working at the home. This person wanted to complain because staff didn't know his needs and how these needs were to be met. We passed to the Clinical Commissioning Group (CCG) the concern raised by this person and will be reviewing this placement.

•□People's care and treatment needs were not provided by staff who knew their needs and how their needs were to be met Staffing levels were maintained by agency and staff from other Glenside Manor locations. On duty at the time of the inspection was a permanent registered nurse, however, all other staff including the manager were new to the service. Two agency staff said they had worked one previous shift at the home. There was one member of staff known as "locum" staff. Locum staff were part of the Glenside staffing but had separate terms and conditions and worked across all locations. Another member of staff from the hospital team was on duty but we were told staffing levels were above the usual numbers with this member of staff. None of these staff knew any of the residents well.

•□People were not receiving continuity of care from regular staff. The registered nurse told us permanent night staff were not on duty at night. The registered nurse said every effort was made to ensure regular agency staff were working at the home.

•□Agency staff did not receive an induction in to the needs of people and their preferred routines when they started work at Pembroke Lodge. The registered nurse said that as an agency nurse was leading the shift the previous day it was "unlikely" the agency staff had received a formal induction on their initial shift. The registered nurse said instead these agency staff had received "direction".

•□There was little evidence to support that agency staff providing care and treatment had the qualifications, competence and experience to do so safely. Effective systems were not in place to ensure that before agency staff worked at the home they were suitable to work with adults at risk, qualified and experienced. We asked the operations director, home manager and registered nurse on duty how they ensured agency staff were suitable to work with adults at risk. The bank and agency worker policy places the responsibility on the agencies to ensure "pre-employment checks to directly employed staff and all workers supplied are duly qualified and experienced." The registered nurse said when the agency office was contacted they requested the specific skills of the agency staff. The registered nurse said, "there is an assumption that agency staff have all the checks and qualifications needed to meet the needs of people at the home." Copies of the staffing rotas showed that 10 agency staff worked 992 hours in January 2019. In February 2019 five agency staff were booked to work 13105 hours at the home. The operations director emailed the portfolio of 12 agency staff which included pre-employment checks, qualifications and experience. However, only one portfolio was for agency staff working at Pembroke Lodge.

•□The above concerns demonstrated a failure to ensure the staff providing care or treatment to people have the qualifications, competence skill and experience to do so safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□One person we spoke with told us they could no longer smoke by the front door where it was sheltered. This person had to smoke at the rear of the property where there was no shelter for smoking. This person told us "when it rains I get soaked smoking outside and worried about pneumonia." We spoke with the operations director who told the person until there was a smoking shelter to the rear of the property smoking was permitted by the front entrance.