Glenside Manor Healthcare Services Limited

Limetree

Inspection report

Warminster Road
South Newton
Salisbury
Wiltshire
SP2 0QD

Tel: 01722742066
Website: www.glensidecare.com

Date of inspection visit:
30 April 2019
01 May 2019

Date of publication:
18 July 2019

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:
Limetree provides care for adults who require long-term nursing intervention and support because of an acquired or traumatic injury, or other neurological condition.

Limetree is one of six adult social care locations at Glenside which also has a hospital that is registered separately with CQC. 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.

The hospital is currently closed due to flooding, caused by a major water leak. People from the hospital were transferred at short notice to some of the adult social care (ASC) locations on the same site. Works to repair the fabric of the hospital building are currently underway. As Limetree was temporarily accommodating people from the hospital we reviewed aspects of these peoples care and support in line with the expectations of their inpatient status.

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

There were concerns about the competencies of some staff to manage the complex care needs of people living at Limetree. There were concerns about the medical cover provided to people who should have been accommodated in the hospital particularly where people had potential medical conditions.

Incidents and accidents were not responded to in line with expectations and requirements. There was a risk that people were being restrained inappropriately.

People were not receiving the one to one support that they required and that commissioners were paying for

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 focus 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.

Limetree

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 another of the registered services sustained a serious injury. We wanted to check that lessons learnt from these incidents had been shared across all the care homes on the Glenside site

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 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:
Limetree 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 seven 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 focus 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 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 potential harm. The provider was failing to meet the medical needs of people including those that had a potential Deep vein Thrombosis (DVT). In addition, the provider was failing to reduce the risk of avoidable harm due to the poor management of medicines. The medical cover for those people who should have been accommodated in the hospital was not robust.
•One person was at risk of being restrained unlawfully.

Assessing risk, safety monitoring and management
•People were at risk from avoidable harm. At least one person had an Endoscopic Gastrostomy (PEG) nutritional tube. The training records showed that not all staff undertaking PEG changes were competent to carry out this procedure. Where staff had received training there was no subsequent assessment of their competencies. Staff, including the training manager, were unclear how often refresher training should be undertaken or how frequently competencies should have been checked.
•One person had a swelling in their leg that could have been caused by a DVT. There were concerns about the clinical management and overview of this medical need. This left the person at significant risk of harm
•Guidance to help staff understand behaviours were not reviewed following incidents of behaviours deemed be challenging. We saw that in March 2019 one person was restrained by at least five staff. The rationale for the use of so many staff was not clearly documented in the care records. We could therefore not be assured that this level of restraint was proportionate and completed in the persons best interest
•Behaviour Charts lacked a description of the behaviours and the actions taken by staff. This meant behaviours were not analysed to ensure behaviour plans gave staff guidance on consistently managing behaviours.
•Behaviour charts and daily reports were inconsistent and when incidents occurred they were not always documented in the daily reports. This meant staff may not be aware of incidents that had occurred that day.
•The person was prescribed medicine, when required, to reduce their anxiety. The protocol for when to administer this medicine was not clear. Due to this it was open to staff interpretation about when to give the medicine.
•One person had been admitted to hospital for urosepsis in the past. We asked staff about sepsis awareness. Staff we spoke with had limited awareness of symptoms but said they would use their clinical judgement.

We noted from the training records that staff had not completed sepsis awareness training
•One person had previously experienced pressure ulcers. The RMO's instruction and the care plan stated, staff should support the person to change position every two hours. The observation charts that we saw did not show any evidence of position changing as directed in care plan and by RMO. This meant there was a high risk of pressure damage occurring again due to lack of change of position.
•The records showed that one person had a fall on 28 April 2019, but the person was not reviewed by the RMO until 2 May 2019. This person was epileptic and had another unwitnessed fall on 3 April 2019 causing bruising to their face. This person did not have a seizure chart to monitor seizures in place and it is not known, as the falls were unwitnessed, if they were caused by seizures. It was unclear from the records if sufficient action was taken in a timely manner to ensure the safety of this person. We could not be assured that the risks to the health and safety to service users receiving care and treatment were mitigated
•Additional concerns were expressed to us by the funding authority regarding people who were commissioned to receive one to one care. One person assigned with one to one staff was not having the agreed support. One member of staff was supporting two people instead of the person at high risk of seizures. Another person had a sensor mat instead of a one to one staff as commissioned. The lack of support in line with the specifications from the funding authority had increased the risk of poor care and placed the person at risk of harm.
•The clinical care for the people who were hospital patients was not safe. Staff were not able to identify and respond appropriately to changing risks to people who used services. National Early Warning Scores (NEWS) was not in use. This issue had been raised at the last inspection in March 2019 and had not been actioned.
•At the last inspection in March 2019 we raised concerns about the standard of nursing notes. Since the last inspection no action had been taken to address this issue. Nursing assessments and documentation were not in keeping with standards for nursing. We found nursing notes were recorded inconsistently. Previous notes were not filed in date order but bundled into an envelope in the notes. This meant that notes to chart a patient's progress were not readily available to staff, for example, agency staff.
•Peoples individual care records, including clinical data, continued not to be written and managed in a way that kept people safe. People's individual care records did not ensure their care was delivered in a safe manner. The provider was not following NICE quality standard 14 statement 12 which states that people should experience coordinated care with clear and accurate information exchange between relevant health and social care professionals. For each person there were up to six different care records, all of which were used by multiple staff and no for the purpose intended. There was an excess of forms and sheets for each of the notes that related to each person. Because of this, there was no way to ensure that all information was accessible at once, meaning no one had overview of a people's entire pathway of care.
•We found that in some patient records there were pages which did not have an identification sticker on which meant that if they sheet got lost, there would be no way to know which patient it belonged to. There were also loose sheets of paper stored in the notes which meant they were easily lost and out of order. There were multiple care plans and risk assessments in the documents which meant there was a risk of a member of staff following the wrong plan. In places handwriting was illegible and staff were struggling to work out what instructions or updates to care plans and actions were.

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
•People were at risk of harm because of poor medicines management
•The registered nurse on duty told us that they had not received any specific training on the administration of medicine through a PEG. We saw that the care plans did not give clear guidance on how tablets should be crushed so that they could be administered through the PEG tube. The registered nurse told us that the

pharmacist advice had not been sought about crushing the tablets. If the tablets were not crushed correctly this would increase the risk of the PEG becoming blocked and could reduce the effectiveness of the medicine.

•We reviewed the records for March 2019 relating to the diabetes management for one person. The care plan on the management of diabetes could not be found easily. The records stated that the person should have had their blood sugars monitored three time a day.

•The plan stated that if the person's blood sugar was above 18 then staff should contact the doctor for advice. There were two occasions in March 2019 where the blood sugars were above 18 and the Dr had not been contacted. The high blood sugar had not been recorded in the nursing notes, so we could not be assured that appropriate action had been taken in response to the high blood sugar

•Staff that we spoke to including the registered nurse were not aware of what the acceptable range for this person's blood sugar.

•We saw that for two people medicine had been stopped by the RMO. These medicines included treatment for underactive thyroid and to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder. There was no clear reason or documented evidence of why these medicines had been stopped.

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 in July 2018 and at subsequent focussed inspections on the 6 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 in another of the care homes on the same site. We also received two incidents relating to poor medicines management in another of the care homes on the same site. Despite these concerns the provider had not taken action to review or implement improvements with PEG or medicines management across all of the care homes
•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.
•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.
•Full information about CQC's regulatory response to the more serious concerns found during this inspection will be added to the report after any representations and appeals have been concluded.
•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