Glenside Manor Healthcare Services Limited

Horizon Close

Inspection report

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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:
Horizon Close 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.

Its aim is to provide maintenance and rehabilitation programmes for adults with long-term neurological conditions. Accommodation is organised into ten bungalows and is one of six adult social care locations which also has a hospital that is registered separately with CQC. Glenside Manor Healthcare Services is not close to facilities and people may find community links difficult to maintain.

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 was closed at the time of our inspection due to flood caused by a major water leak in January 2019. Patients from the hospital were transferred at short notice to some of the adult social care (ASC) locations.

People's experience of using this service:

The provider failed to apply for an extension of the regulated activity to accommodate hospital patients in ASC locations. Although the provider had notified us of the temporary arrangements for hospital patients while refurbishments were taking place. We informed the provider at the time and at inspections that to continue offering accommodation to hospital patient's they must submit applications to CQC. This was to ensure hospital patients were cared for in a manner that met the regulated activity.

People were not safeguarded from abuse and were placed at some risk of harm.

Medicines were not well managed and the potential for errors was increased.

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 at the focus inspection dated 7 November 2018 was Requires Improvement. This report

was made final on 20 February 2019. The overall rating of this service was changed to Inadequate.

Why we inspected:
This inspection was brought forward due to information of risk or concern about people living in all ASC locations. After the inspections of other ASC locations 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.

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.

Horizon Close

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 clinical management. This inspection examined those risks.

Inspection team:
This inspection was carried out by two inspectors, a specialist advisor, pharmacist and an assistant inspector. There were three inspection managers on site overseeing the inspection.

Service and service type:
Horizon Close 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. 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. Despite CQC informing and reminding the provider, an application for a registered manager has not been submitted. This meant the provider was failing to comply with the conditions of their registration.

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 one person in depth, accidents and incident reports. Audits and quality assurance reports.

Inadequate

Is the service safe?

Our findings

We inspected this key question at the comprehensive inspection dated 10 October 2018. At this inspection we found little evidence that reporting systems lead to learning from accidents and incidents. These events were notifiable under safeguarding and to CQC under Regulation 18 but were not reported as required. While the action plan provided was outside the timescale given there was little evidence from the plan that compliance was reached. The provider consistently failed to comply with this requirement since this and subsequent inspections.

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. At our last inspection we raised concerns about the lack of a robust safeguarding system. We had identified that some incidents were not reported to safeguarding and to CQC as required. We told the provider they needed to improve their safeguarding systems and processes to ensure incidents were appropriately reported.

Assessing risk, safety monitoring and management

● People were at risk from avoidable harm. Documents for one person showed a fall had occurred in January 2019 but monthly reviews did not include detail of this fall. Accident reports were not recorded in the homes online recording system. This meant senior managers were unaware of the falls and an analysis of falls were not undertaken.

Using medicines safely

●Medicine systems were not safe. Accurate and up-to-date records of medicines in stock were not maintained. The quantities of medicines received were not documented on the Medication Administration Record (MAR) of medicines carried forward. The provider could not be certain that people were having their medicines as prescribed. This meant systems for auditing medicines were not robust.

Inadequate

Is the service well-led?

Our findings

At the previous inspection dated 10 October 2018 we found a breach of Regulations 9, 17 and 18 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 Regulations 9, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection, the provider failed to report within the given timescale on the intended actions to meet breaches of Regulations. At this inspection we found continued breach of Regulation 17.

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 October 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 the last comprehensive inspection completed on 10 October 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.

•At 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 plans would be submitted. At this inspection we found that the improvements had not been implemented in line with these assurances.

•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 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 followed 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 were 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's 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 these inspections 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

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents CQC were not kept informed of incidents and accidents

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The findings of this inspection show a continued breach of Regulation 12 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 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