Glenside Manor Healthcare Services Limited

Newton House

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:
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.

One adult social care location (Pembroke Lodge) is currently closed as there were ongoing and continual issues with the provision of heating and hot water.

The hospital is also currently closed due to a flood caused by a major water leak. People from the hospital were transferred at short notice to some of the adult social care locations on site. Works to repair the fabric of the hospital building are currently underway. People from the hospital were not being accommodated at Newton House.

People's experience of using this service:
The service did not have a registered manager in post. The service was being managed by an interim manager.

People were placed at risk from poor management. We found systemic overarching poor management systems and that improvements were not prioritised. There had been sudden and persistent changes of senior managers. There was a lack of regulatory response from the provider. There were poor recruitment procedures, and a lack of investment with equipment and maintenance of the property. The morale of the staff was low and they were reluctant to give feedback because of fear of reprisals. This had an impact on the care people received.

Whilst we saw that some improvements had been made these were not sufficient to improve the ratings. Improvements had been made since the focus inspection dated November 2019 with the provision of equipment. However improvements with the supply of equipment had not always resulted in better outcomes for people. The environment still required improvement and there were still concerns about maintenance of the premises

People were not always protected from risks associated with their conditions. Medicines continued to be managed in a way that was not always safe.

Some staff were positive about management changes and felt supported by the home manager of Newton House.

There were still concerns about staff trust in the provider and the overarching management systems for the site as a whole. There continued to be a clear disconnect between management on the Glenside site and the provider resulting in poor responses to the areas of concerns identified by CQC; partner agencies and as a result of the previous inspections.

Rating at last inspection:
Requires improvement. Full comprehensive inspection published 2 October 2018.

Why we inspected:
This inspection was brought forward due to information of risk or concern. Following the comprehensive and focus inspections CQC have received on going whistleblowing concerns. After the last inspection CQC requested assurances from the provider about the action they would take to improve the service. To date these assurances have not been forthcoming.

Enforcement:
Following the last inspection we imposed a condition on the providers registration to submit monthly improvement action plans to CQC. However, the action plans from February 2019 had not been received.

Follow up:
The overall rating for this service has changed to Inadequate. 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.
• 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.

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 always safe

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The service was not always well-led

Details are in our Well-Led findings below.

Newton House

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 in part by whistleblowing and the lack of ongoing assurance that the required improvements were being implemented following the last inspection.

Inspection team:
The inspection of Newton House was completed by one inspector. A team of inspectors inspected the other locations which are situated on the same site.

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. A 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 was unannounced.

What we did:
We obtained feedback from one person using their preferred method of communication. We spoke with the interim manager, the nurse and two care staff.

We looked at one person's care record and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

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

- Staff were confident to raise concerns and felt that action would be taken to protect people from harm and abuse.

Assessing risk, safety monitoring and management

- Care plans contained a range of risk assessments including medicines, mobility and choking. However, care plans did not always include up to date, consistent information in how to manage the risks. For example, one person's mobility care plan identified the sling they required had changed due to a change in the person's weight. However, this information had not been updated on the person's 'summary of needs' document which still contained details of the previous sling.

- We are not assured that all staff had received the necessary guidance, training or of their competency to use MAPA techniques safely. This would leave people at staff at risk of injury or harm. It was not always clear that appropriate action had been taken to ensure risks associated with behaviour were managed effectively. For example, a person's 'support to manage behaviour' care plan stated, 'If needed use Management of Actual or Potential Aggression (MAPA) techniques'. The care plan also stated that a referral had been made to psychology. An entry dated 8 June 2018 stated the psychologist had cancelled the appointment and that the care plan should remain in place. There was no other entry relating to a psychologist visit and the care plan had not been reviewed or updated.

- Suitable equipment was not provided to all people that needed assistance with personal care. The staff were not always trained to use equipment safely. At the time of our inspection there were two hoists in the service for eleven people. Staff told us this was sufficient to meet people's needs. They said a new shower chair/bed had been purchased since our focus inspection in November 2018. However, staff told us this could not be made available to all people as it was too big to manoeuvre in the narrow corridor. Although alternative arrangements had been agreed between the manager and staff, two people had not yet been able to use the shower. Staff told us this was because an appropriate hoist was only made available two days before our inspection. They also said the staff were not experienced and available to support these people to use the shower safely.

- There were concerns about the safety and maintenance of the buildings. One member of staff told us, "The biggest problem we have at the moment is maintenance. They don't have the basics to put things right." The system for reporting maintenance issues was not robust. Following our previous inspections, we were not assured that maintenance staff had the skills and competencies to fulfil their role due to a lack of training and basic English language skills.

The above concerns demonstrated a failure 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

Staffing and recruitment

•□There was a lack of continuity of care from staff recruited to work permanently at Newton House. The staff we spoke with told us staffing levels were maintained with mostly agency staff. These staff told us there were high levels of agency staff being used. The home manager told us they tried to ensure consistent agency staff were used. We looked at rotas for March 2019 and saw that permanent nurses had been on duty for only three days in March 2019. On the day of the inspection a nurse from the hospital on Glenside site was deployed to work at Newton House. All night shifts showed permanent staff working.

•□There was little evidence that agency staff working at the home had the experience needed to meet the needs of people. The manager was not able to provide profiles for the agency staff on duty on the day of our inspection. We could therefore not be assured that the agency staff had the appropriate skills or competencies to meet the individual needs of the people living at Newton House.

•□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 continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

•□Medicines were not always managed safely. Records relating to the positioning of transdermal patches were not always completed. For example, one person was prescribed a transdermal patch to be applied weekly. A transdermal patch is an adhesive patch which is placed on the skin to deliver medicine through the skin. The transdermal patch record stated 'do not apply to the same site for three weeks'. The medicine administration record showed the patch had been applied on 7 March 2019. There was no record of where the patch had been placed on that date. This put the person at risk of not receiving the patch on the 14 March 2019 in line with prescribed guidance.

•□The home manager said that monthly medicine audits were completed to identify any areas for improvement. However, there was no audit for February 2019 available.

•□Medicines were stored safely in a locked room with keys only available to the nurse responsible for administering medicines.

Preventing and controlling infection

•□Clear information and guidance relating to infection control was not available. One member of staff asked the inspector to wear personal protective equipment when entering a person's' room as they had an infection. There was no information in the person's care file. We spoke to the home manager who told us the person had a wound infection following a hospital admission that was now cleared. We saw records that confirmed this.

The above concerns demonstrated a failure 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 manager had appointed an infection control lead and hand hygiene assessments were being completed of all staff.

•□The environment was clean. The home manager told us that cleaning arrangements had improved and that Newton House now had an allocated cleaner. There was a cleaning supervisor who visited Newton House weekly to check the cleanliness of the service.

•□There were areas of the service that required refurbishment. The home manager told us that the plan was to move people temporarily into a neighbouring service to enable Newton House to have a complete refurbishment. Letters had been sent to families and representatives of people living in the service advising them of the planned move. No date had yet been set for the move.

Inadequate

Is the service well-led?

Our findings

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 a subsequent focussed inspection on the 7 November 2018 we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following 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.

•After the last inspection 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.

•There was integrated working within CQC directorates in relation to Adult Social Care (ASC) and Hospital directorate. We took enforcement actions for all ASC locations and at the hospital. Following the last inspections of all ASC locations 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. We have not received action plans from February 2019. This meant the provider was not meeting the conditions of their registration.

• We also issued warning notices following the inspection of the hospital. Action had not been taken to meet these warning notices.

• There was partnership working 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. The CCG have told us that they were currently reviewing the care needs of people across the whole site. In response to these reviews alternative placements were being sought for some people as well as patients. CQC continue to work with other agencies to ensure the safety of people

•At this focused inspection we found continued breaches of Regulation of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

•□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.

•□Robust action plans were not developed to meet the conditions imposed by CQC. The home manager had recently developed an action plan for Newton House in order to address the concerns found at our last inspection. The Chief Executive Officer (CEO) confirmed the home manager had shared the action plan for review and agreement. However, the provider had not shared the enforcement action imposed by CQC. Contractual agreements with partner agencies on how standards of care were to be adhered to were not made known to managers. It is unclear therefore how the manager could have considered all the remedial action required when developing the action plan.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

•□There was a lack of communication and oversight between the provider and senior management at the Glenside site.

•□We found the senior management team was 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. One member of staff told us, "[Provider] is the main man and makes all the decisions. Chief Executive Officer (CEO) can try and put things right but [provider] can stop her if he disagrees".

•□Following the focus inspection dated 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.

•□At the time of the inspection there was staff confidence in the actions of the newly appointed Staff described the CEO as caring and believed that actions being taken were improving the service. Comments included: "I get very good support from [CEO] recently. It has been crazy. Things have settled quite a lot" and "[CEO] is making things better. Very caring about us and the patients. She comes if we need her".

•□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. At the comprehensive inspection, in November 2018, we found that 240 staff across the Glenside Manor and hospital had left since 2017. After this inspection we were informed of the resignation of a number of other staff across the site. This high turnover of staff impacts on the morale of the remaining staff; raises concerns about the continuity of care to people using the service and calls into question the culture of the service which some staff described as "bullying".

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

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Despite the concerns about the overarching management systems staff had confidence in the current home manager and felt listened to and supported. One member of staff told us, "[Manager] is very good. So many things have got better. Very good for us, for equipment and very good for service users. We can ask for anything and he can resolve problems".

•□The home manager had held staff meetings to keep staff informed and to help them understand the changes that were happening. The home manager told us, "It is important that I work with staff. Gain their trust and respect and encourage them to take ownership of the improvements at Newton House".

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