Glenside Manor Healthcare Services Limited

Old Vicarage

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:
13 August 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:

The Old Vicarage is a care home for 22 adults with acquired or traumatic brain injury, or other neurological conditions. At the time of our inspection there were 15 people accommodated. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement.

The Old Vicarage is one of six adult social care locations at Glenside which also has a hospital that is registered separately with CQC. 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 locations and at the time of our inspection, three patients were accommodated. We reviewed aspects of these patients care and support in line with the expectations of their inpatient status, with assistance of CQC colleagues from the hospital's directorate.

The provider 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 is to ensure the regulated activity for hospital patients was provided at Old Vicarage. However, the provider failed to do this which meant the Old Vicarage continues to be incorrectly registered.

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

Medicines were not well managed. Medicines Administration Records (MAR) were confusing. This increased the risk of errors.

There were concerns about the competencies of some staff to manage the complex care needs of people living at Old Vicarage. There were concerns about the medical cover provided to people who should have been accommodated in the hospital.

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 focused 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.

Old Vicarage

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:
Old Vicarage 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. Despite CQC informing and reminding the provider, an application for a registered manager has not been submitted.

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 three people in depth, 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 failed to provide an action plan on how they were to meet the requirements made at the comprehensive inspection dated 2018. 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. At this inspection, we found the same issue, for example, we found a record of one person who had been discovered with a significant bruise. This had not been escalated, and no safeguarding alert had been made, despite the records stating there was no known cause for this injury. When we asked staff about this, they told us they did not consider this as a safeguarding cause for concern. We were not assured that staff understood their duties in relation to safeguarding people at risk, or that all incidents were being appropriately investigated.

• During our last inspection we found evidence that The Deprivation of Liberty Safeguard (Dols) was not being managed appropriately. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

One person's behavioural support plan stated they were currently subject to DoLS restrictions and were accommodated in a care home which restricted people from leaving. The action plans from this care plan was for the DoLS to be reviewed monthly to ensure the least restrictive option was imposed and were in the persons best interests. We saw that this behavioural support plan, containing the details about the Dols had been reviewed on 24 April 2019. We asked the registered nurse on duty about the Dols in place, they told us that the care plan was wrong, that the person had no DoLS in place. There were no records in place to confirm this. Due to this we could not confirm if the person was being restricted lawfully.

• The Old Vicarage was not registered to care for people detained under s.3 of the Mental Health Act 1983. One person who was under section three was accommodated at the location without a valid leave authorisation to cover the transfer from the hospital to the Old Vicarage as required. The person may be at risk of harm without a valid and appropriately risk assessed leave authorisation covering the person's current location. We advised the provider of this and required them to take action, but they failed to do so.

Assessing risk, safety monitoring and management

• The provider was failing to meet the medical needs of people including those that had pre-existing medical conditions such as diabetes, epilepsy and cardiac complaints.

• We found evidence in the three care files we reviewed in depth that people with ongoing medical conditions that were not being consistently managed. Although one person required regular specialist support they had not had any input from a specialist for over four years. A referral for this medical condition was not made until April 2019 when the person was experiencing symptoms related to their condition. This person then attended the outpatients department without any written referral or information about their condition or symptoms. At the time of the appointment the hospital consultant was unable to speak to the Glenside staff who knew this person and their condition. This resulted in a delay in treatment for this person who was unable to provide details about their condition due to their neurological condition. The Glenside staff received feedback from the consultant in the form of a complaint, which remained not addressed.

• We saw examples of other people with insulin dependent diabetes who had not had specialist referral or input. There were people whose brain injuries related to their diabetes, and despite their blood glucose levels being poorly controlled, we found insufficient action was taken to ensure the clinical management plans, including their insulin regimes were appropriate. We were concerned about the lack of a clinical plan with rational for the regimes, as well as lack of appropriate actions or reviews taking place when their blood glucose levels were outside of normal ranges. We asked the provider about their regimes and even though they had not been clinically assesses we were told advice had been taken verbally over the phone from the local hospital. This advice did not appear in the persons records so we could not be sure it was appropriate or sufficient. We saw one referral had recently been made to the diabetic clinic, however, this had been sent to the wrong address and not been followed up until we asked for the evidence of referral.

• We found evidence that where blood glucose levels were outside of normal ranges, action was not always taken, even though the high levels were recorded. In relation to one person, staff we asked were not clear when they should contact the doctor as they said it was usual for the person to have high blood sugar levels. There was a significant risk of harm to the person as staff were not clear on when to contact the Resident Medical Officer (RMO) for additional treatment and the RMO was not consistently contacted when the blood sugars were outside of normal limits. Some blood glucose readings were not being taken or recorded. Between 27 March and 9 April 2019 (15 days) for one person, there were only six pre-supper readings, 11 pre-tea readings 11 pre-lunch readings and 13 pre-breakfast readings. Readings fluctuated considerably on each day, and on some days, insulin was given and other days there is no evidence that high readings were escalated or insulin given. Where there were high readings, blood sugars were not always rechecked to determine improvement. For example, on 19 April 2019, one person's blood sugar was elevated at lunch and at supper, but no record is made of any insulin being given. This put the person at risk of harm where blood glucose levels are not monitored appropriately or treated in accordance with best practice.

• Where people's blood glucose levels were outside the normal range there was no evidence of staff having followed instructions to reduce the risk. For another person, on 12 March 2019 records show the blood glucose level before bed were high (23.9). There was nothing recorded in terms of action taken or escalation. The next reading was the following morning which showed a reading of 18.4. On 21 March 2019 the blood glucose reading of 19 was escalated to the RMO and instructions were recorded to monitor blood sugar overnight. There was no evidence this was done. On 23 March 2019 the staff recorded the person was presenting as confused and disorientated with a blood sugar of 18.5. However, the nursing records did not show any escalation and stated, "blood sugar in manageable range". No insulin was given as per the prescription and the person was not reviewed by the RMO putting the person at risk of harm.

•□Methods for monitoring dietary intake were inadequate. There were four separate places for staff to record diet and fluids intake which staff had not fully completed and provided little evidence on how they were monitored or analysed., This meant people were at risk of harm as the staff would not be able to track or monitor potential causes for fluctuation in blood glucose levels, or to determine the best insulin regime.

•□There was no formal system in place to review people for signs of deterioration. Staff we asked told us formal observations were not taken on people because they had behavioural difficulties and would not always consent. The RMOs however, told us that each person should have observations recorded at least once each day, and more often if there were concerns, but this was not being done. There was no National Early Warning Score (NEWs) system in place to assist staff in early detection of deterioration, or with appropriate escalation. None of the records we reviewed had regular observations recorded, even where the person had expressed feeling unwell. One person had been complaining of flu like/infectious symptoms and feeling generally unwell, but the RMO did not review this person for two days. When the person was reviewed, one of the observations was outside of normal limits, yet this reading was not repeated, and no further action was taken. For this same person, there were also safeguarding issues that were not identified or addressed.

•□The provider was failing to reduce the risk of avoidable harm due to the poor management of medicines. We found the prescription charts for people to be confusing and lacking clear instruction, for example with regard to insulin regimes. One person had two charts which were numbered as 'chart 3' and 'chart 4'. We could not locate 'charts 1 or 2' and staff were unable to tell us if there were additional charts for this person, which meant potentially medications were being omitted. In some charts there were no special instructions recorded and in others they were confusing, for example, "if blood glucose above 18, give between 4-8 units of insulin." It was not clear what the dose was that should have been given or how staff determined how much to give according to the blood glucose level. It was also not clear how much had been administered, as staff initialled administration of insulin but the dose was not always recorded.

•□When we reviewed the medications that people were prescribed, we were unable to find any rationale for certain medications. When we asked the RMO and the provider to explain how they prescribed, managed and reviewed medications, we were told they were copied across from their admission details. We found no evidence of these medications being reviewed since the persons admissions, and we could not be assured, given the lack of clinical plans and specialist input, that the medications people were being given remained appropriate to their needs.

•□People were at risk of dehydration. One person was on a nutritional care plan that was completed on 10 April 2019 and stated that the person needs '2.5 litres of fluid per day and escalation to RMO if below 1000 ml over 12 hours'. This person should have closely monitored fluids due to their condition, and as the person was not able to manage their own fluid intake. On 29 April 2019 only 900ml was recorded, on 28 April 2019 only 200ml was recorded, 27 April 2019 none recorded, 26 April 2019 450ml, 25 April 2019 200ml, 24 April 2019 400ml. This put the person at risk of harm due to inadequate fluid intake and dehydration and was contrary to the persons plan of care.

•□There are inadequate systems and processes in place to risk assess people who may be at risk of self-harm or suicide. We found examples of such high risk people who did not have risk assessments in place.

•□One person had significant behavioural support needs, including frequent violent outbursts. Within their daily behaviour records and observation records we saw that that seven incidents had occurred between

the dates of 21 April to 30 April 2019. Staff had, recorded episodes where the person had hit and punched staff or hitting out at other people. The provider had an electronic reporting system policy which stated that incidents involving physical contact should be formally reported via the reporting system. We asked staff what types of incidents should be reported. Staff confirmed that hitting a member of staff or another people should be reported. We reviewed the incident data for this time period and found that only one incident which had taken place on 30 April 2019 had been reported. We were concerned that the provider had no oversight of their reporting system and that staff were not reporting incidents as per the policy. This meant t there was no management oversight of risks of harm to people, staff and others. Also, that behavioural support plans did not give staff guidance on how to manage situations to effectively support the person and others.

• Systems and processes were not in place to ensure appropriate one to one care was provided or recorded as required. We reviewed a number of one to one forms for people and found they had not been completed. These should be completed by staff daily and record all forms of intervention provided to deescalate behaviours which challenge. Examples given for staff to report upon include medication, verbal prompts, distraction techniques, interaction and engagement. The record we reviewed included such incidents which had not been recorded on the one to one forms, or via the electronic reporting system.

• People and staff were placed at risk in the event of an emergency. There was a nurse call system in place which was not fit for purpose. The front door bell activated the nurse call alarm as well as the call bells in each room. It was not possible to identify where the alarm was coming from, as there was no lighting or overview system to direct staff to the correct place. This meant a delay in finding who was calling. In addition, if the alarm was not deactivated within one minute, the emergency alarm system would activate. During our inspection, for in excess of four hours on Old Vicarage one afternoon, the emergency alarm was sounding continuously. We asked staff about this, and they told us they were used to it, and it took time to find out who was calling. This meant that staff would not be able to differentiate between a routine call alarm and an emergency, and therefore would not necessarily respond in a more urgent way as required, placing both people and staff at risk.

• At the last focus inspection in March 2019 we raised concerns about the standard of nursing notes. 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 person's progress were not readily available to staff, for example, agency staff.

• People's individual care records, including clinical data, continued not to be written and managed in a way that kept people safe. Peoples 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 records, all of which were used by multiple staff for different purposes. There were a plethora of forms and sheets for each of these notes relating to people's care. 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 records there were pages which did not have an identification sticker which meant that if they sheet got lost, there would be no way to know which person 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 arrangements for providing competent and skilled medical cover for hospital patients were not sufficient and put them and others at risk. There were two Resident Medical Officers (RMOs) employed by the service who worked one week on and one week off in rotation. We were not provided with any evidence of contingency plans in the event of illness or annual leave, and we were not assured the arrangements in place were robust enough to ensure safe cover at all times.

• We found evidence that the RMOs had not received the appropriate training for some key subjects, including PEG management, and advanced life support. The supervision arrangements for the RMOs as required by their licence to practice were not formalised and we were not assured that appropriate supervision had been taking place. We requested evidence of appraisals for both RMOs but we were not provided with these. We have shared our concerns with the General Medical Council for further consideration.

• We were concerned to find some key referrals for specialist input for people had not been made in a timely manner, for example people who had diabetes or other medical conditions such as cardiac disease or epilepsy. We were unable to locate clinical plans for some people who had enhanced care needs. This meant staff were not able to readily identify clinical management for people as prescribed. When we asked for the clinical plans, the RMOs provided us with a word document containing notes from a ward round. The information had not been written into the person's notes or care plan and was held on the RMOs laptop.

• There were no formal agreements in place for the RMOs to obtain specialist clinical advice, and they relied on an ad hoc system of ringing the local hospital for advice. We saw evidence of the RMOs acting on this advice without ensuring the person was referred for a comprehensive assessment by an appropriate specialist.

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 focused 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 on 29 and 30 August 2018 and at subsequent focussed inspections on the 7 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 we were informed of two incidents that caused harm to two people due to poor management of PEG's. We also received two incidents relating to poor medicines management. Despite these concerns the provider had not taken action to review or implement improvements with PEG or medicines management

•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 cancelling their registration 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 focused 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 teamduring November 2018 and the subsequent deregistration of all registered managers for Adult Social Care (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.

•□Full information about our regulatory response to the more serious concerns found during this inspections will be added to the report after any representations and appeals have been concluded.

•□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 our pending enforcement action alternative placements were being sought for all people. We will continue to work with other agencies to ensure the safety of people

•□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 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