Glenside Manor Healthcare Services Limited

Langford/Kennet

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:
Langford and Kennet are two eight bedded units that are managed as one service and provide complex nursing care for people with neuro degenerative or previous brain injury. 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 also 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 Langford and Kennet were 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 risk of harm.

Medicines were not safely managed. Medicines Administration Records (MAR) were confusing which increased the risk of errors. Care plans lacked detail on how to administer medicines safely to prevent Percutaneous Endoscopic Gastrostomy (PEG) blockages. One person received their medicine 'covertly' (without them knowing). The decision to give the medicine in this way had not been reviewed. Medicine that was out of date was observed being administered. Following the inspection, we received concerns about the management of one person's medicine which would have left the person at risk of harm.

There were concerns about the competencies of some staff to manage the complex care needs of people living at Langford and Kennet. 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 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.
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.

Langford/Kennet

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 in 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 services 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, a pharmacist and an assistant inspector.

Service and service type:
Langford and Kennet 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 held 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 tracheostomy and those people who had their nutritional needs met through Percutaneous endoscopic gastrostomy (PEG) tubes. 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

Assessing risk, safety monitoring and management

- People were at risk from avoidable harm. The training records showed that not all staff undertaking PEG changes were competent to carry out this procedure. If staff had received training there was no subsequent assessment of their competence. Staff, including the training manager, were unclear how often refresher training should be undertaken or how frequently competencies should have been checked.

- People were at risk of dehydration. For people with PEG's the dietician had formulated a plan of fluids to be given by staff. The fluid charts we reviewed did not confirm that the fluids had been given in line with the plan. We reviewed four people's fluid balance chart and found that that these showed that some people were in negative balance. We spoke with a staff member about the number of water flushes given via the PEG and the no actions taken in response to the negative fluid balance. We were not assured this was always safely managed by staff to prevent the potential risk of dehydration.

- Two people were supported with their breathing through a tracheostomy. A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help people breathe.

- There was some inconsistent recording of when the tracheostomy was changed. The plans stated that the tubes should be changed every 28 days. There were two different forms for the recording of the tube changes. This increased the risk that the tubes changes would be missed. We did not find any evidence of tracheostomy tube change in January 2018 and December 2018. We spoke to the registered nurse who could not confirm that the tubes had been changed and could give no explanation for the use of the two separate forms.

•□The cuff pressures for the tracheostomies were recorded frequently. The recorded values ranged between 25 to 30 cm H2O. However, the, national guidance (Intensive Care Society Standards 2014 guidance on cuff pressure) recommends cuff pressure should 'be below 20-25 cm H2O to avoid risk of internal pressure damage. We asked staff about this who referred to the 'Glenside' training material which stated cuff pressure should be 15 to 32 cm H2O. The staff member told us that they would raise this with the training department for review.

•□Emergency equipment was in place. This emergency equipment should be checked daily in line with care plan and good practice. The check was documented in different ways for different people and could cause confusion.

•□We observed four oxygen cylinders in one person's room which were placed in designated wall mounted racks, but they were not securely strapped in to ensure they were not accidently knocked over. We pointed this out to the registered nurse who told us that they would ensure this was corrected. However, when we returned the following day, three of the four cylinders were still not correctly strapped into the designated rack.

•□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 use 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. 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 people's records there were pages which did not have an identification sticker on which meant that if the 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 arrangements for providing competent and skilled medical cover for people that should have been accommodated in the hospital was not sufficient and put people 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 patient'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 patient 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.

Using medicines safely

•□People were at risk of harm because of poor medicines management

•□One person had a urinary catheter in place. When the catheter was changed this caused the person anxiety. Because of this they were prescribed medicine to be taken before the catheter change to reduce their anxiety. When we reviewed the MAR (Medicine Administration Record) and cross referenced this to the care notes we found that the diazepam had not been given as prescribed before a catheter change. This could have caused the person increased anxiety and distress.

•□Two people were prescribed a steroid cream to reduce the inflammation of their PEG site. When we looked at the cream we saw that it was dated as being dispensed on the 26 November 2018. There was no date that the cream had been opened. Once opened the cream expired after four weeks. When we looked at the drugs that had been ordered there was no evidence that additional cream had been dispensed since November 2018. Records showed the cream had been used up to three times a day including on the day of the inspection. Using expired cream would reduce the effectiveness of the cream and increase the risk of infection.

•□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 the pharmacist's 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.

•□Following the inspection, we received concerns from a visiting health professional about the administration of one medicine through a pump for a person. The pump required "topping up" by the resident medical officer. This had not been completed and staff had not recognised that this was required. When this was raised with staff at Langford and Kennet the equipment required to 'top up' the pump could not be found. The person required a trip to hospital to have the medicine added to the pump. The lack of topping up the pump could have caused a serious injury; too little medication, which could lead to withdrawal symptom or damage to the pump, which would require surgery to replace the pump.

•□One person was having their medicine covertly (hidden in food or drink so that the person did not know they were taking the medicine). The decision to give the tablets in this way was made in 2016. This decision had not been reviewed since this time to ensure it remained necessary to administer in this way.

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 on 9 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 services on the same site. We also received two incidents relating to poor medicines management in another of the services 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 their 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 are required.

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•□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 was 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. 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 living at Glenside.

•□ Full information about CQC's 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. Since this inspection the providers have taken action.

•□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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 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.

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
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.