Glenside Manor Healthcare Services Limited

Newton House

Inspection report

Warminster Road
South Newton
Salisbury
Wiltshire
SP2 0QD

Tel: 01722742066
Website: www.glensidecare.com

Date of inspection visit:
07 November 2018

Date of publication:
12 April 2019

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We undertook an unannounced focused inspection of Newton House on 7 November 2018. After the comprehensive inspection dated on 29 and 30 August 2018 we received concerns in relation to staff not having appropriate checks before starting employment, language barriers of staff, poor working and living conditions for staff working as agency staff, competency of staff undertaking maintenance checks and lack of equipment across the Glenside Manor site. As a result, we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those concerns. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Newton House on our website at www.cqc.org.uk.

The team inspected the service against two of the five questions we ask about services: is the service well led and safe. This is because the service was not meeting some legal requirements.

No risks, concerns or significant improvement were identified in the remaining Effective, Caring and Responsive through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

Newton House provided nursing care for up to 16 adults with progressive neurological conditions. It 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. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Each of the services is registered with CQC separately. This means each service has its own inspection report. The ratings for each service may be different because of the specific needs of the people living in each service. While each of the services are registered separately some of the systems are managed centrally for example maintenance, systems to manage and review accidents and incidents and the systems for ordering and managing medicines. Physiotherapy and occupational staff cover the whole site. Facilities such as the hydrotherapy pool are shared across the whole site.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission 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.

At the previous inspection dated 29 and 30 August 2018 we found breaches of Regulations 9 and 12 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 Regulation 9 and 12. 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 this focused inspection we found continued breaches of Regulation 12 and a breach of 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The CQC following the inspection formally requested under Section 64 of the Health and Social Care Act 2008 to be provided with specified information and documentation by 16 November 2018. We received some of the information requested but not all.

Quality assurance systems were not effective. We requested copies of audits on how the delivery of care was assessed and monitored and only received copies of the environmental audits. We noted there had been shortfalls and poor standards of cleanliness and lack of hand washing equipment. Where shortfalls were identified action plans were not developed to improve care and treatment to people. The CQC was not notified of accidents and incidents reportable under the Care Quality Commission (Registration) Regulations 2009: Regulation 18.

The CQC received whistleblowing concerns about staff not being able to speak sufficient English. These staff were referred to as "agency staff" and were working without appropriate checks. We found there were some staff working across the site without the appropriate disclosure and barring checks or written references in place.

Recruitment procedures did not ensure the staff employed at the home were suitable to work with adults at risk. There were staff employed through a recruitment agency and referred to as "agency staff" because of their terms and conditions. The HR assistant was not able to show that agency staff recruited were suitable to work with adults at risk.

New staff did not always have an induction to prepare them for the role they were employed to carry out. We were not able to verify that new staff had an appropriate induction before starting work. We were informed that not all staff had received an induction or mandatory training due to the level of the English they spoke and understood. We were told staff responsible for training would not be able to sign new staff as competent as their English was so poor.

Whistleblowers told us senior managers were unaware of staff working and accommodated within Glenside Manor. We received concerns about staff known as "agency staff" as they were not directly employed by the provider but introduced to the provider by recruitment agencies. There were a number of staff on site whose identity could not be confirmed by the most senior staff on duty. The list of agency staff provided on the first day of the inspection was not up to date as we met another 11 agency staff not included in the list and covering a variety of roles

The documents provided under Section 64 did not provide confidence that staff working at the home were trained for their role. The staffing list provided included the names of 15 staff with the role of delivering direct care for up to 12 people. While the training matrix listed the names of nine staff as having attended training there were eight staff in the staffing list that were not included in the training matrix. This meant there was no evidence that the six staff were trained.

Staff morale was poor and staff told us they feared about their jobs as they had witnessed other staff being dismissed almost daily. The staff survey provided under Section 64 of the Health and Social Care Act 2008 indicated that 13 of the 38 staff responding would recommend the home.

The CQC received whistleblowing concerns about the competency of the staff undertaking maintenance

checks of systems and equipment. The CQC following the inspection requested proof of the competency of these staff from the provider. The documentation provided under Section 64 of the Health and Social Care Act 2008 did not give CQC reassurances that staff undertaking maintenance checks were skilled or competent.

The information received from relatives about raising concerns was not consistent with the complaints log.

The overall rating for this service is 'Requires improvement'. However, 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.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe

Recruitment was not managed safely and staff were working across the site without appropriate checks.

There was insufficient equipment for transfers.

Repairs of the property were not undertaken by staff that had the qualifications or specific skills.

Is the service well-led?

Inadequate

The service was not well led

The quality assurance systems in place were not effective. Audits were not robust and did not assess all areas of service delivery. Action plans were not developed on driving improvements.

CQC were not notified about incident and accidents of events reportable by legislation.

Staff morale was poor and they were fearful for their jobs.

Newton House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, 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 by whistleblowing concerns. These involved staff not having appropriate checks before starting employment, language barriers of staff, poor working and living conditions for staff working as agency staff, competency of staff undertaking maintenance checks and lack of equipment across the Glenside Manor site.

Information of concern was shared and consultations were held with CQC colleagues in the hospital directorate, Wiltshire Council Safeguarding and Commissioning and Clinical Commissioning Group (CCG). Associated agencies that that have regulatory powers for the safety of the premises and staff were made aware of concerns.

This inspection took place on 7 November 2018 and was unannounced.
The inspection was carried out by two inspectors.

We observed people with staff in communal areas. We spoke with the registered manger, deputy manager, registered managers from other locations and rehabilitation assistants including senior rehabilitations assistants. We also spoke with the office manager, quality and safety lead, HR assistant, maintenance staff, night manager, catering staff and chef.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection dated August 2018 we found a breach of Regulations 9 and 12. We found Care plans were not person centred and did not always provide information to staff on people's choices and preferences. Procedures were not in place for medicines prescribed to be taken "when required" (PRN). Records of medicine patch applications did not show that manufacturer guidance was followed. Systems in place that ensure air mattresses were set correctly were not robust. We asked the provider following the inspection to tell us how they were going to meet these regulations. The provider failed to report on the actions to meet the Regulations 9 and 12 of Health and Social Care Act 2008, its associated regulations, or any other relevant legislation. At this focus inspection we found continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Equipment for transfers and to move around the home was not safe for people to use. We received whistleblowing concerns before the inspection that equipment and aids were in need of repair. Whistleblowers told us during the inspection that a specialist shower aid was not safe to use. It was not connected to the breaks when a person's weight was put on it. During the inspection the staff demonstrated the difficulties experienced when navigating the shower tray in the wet room. On the 7 November 2018 the acting operations director and maintenance manager looked at this aid and said it was ok to be used. The staff at Newton House told us they had refused to use the shower aid. They said as the maintenance staff had tried to repair the shower tray unsuccessfully and external contractors had refused to carry out any repairs because of this.

People were not receiving their personal care in a timely manner. Whistleblower told us there were insufficient hoists for transfers. The staff told us there were 12 people that needed support with transfers. The staff on duty confirmed personal care was delayed because there was one hoist to be shared with 12 people. The staff told us there had been a complaint from a relative about personal care not being delivered in a timely manner which this relative believed had caused skin damage.

Whistleblowers also told us "people's wheelchairs are no longer getting serviced." They also told us about an incident where the call bell system was not operating effectively. It was explained that the maintenance manager had cut the cord to stop the call bell from ringing instead of repairing the fault.

The CQC following this inspection formally requested under Section 64 of the Health and Social Care Act 2008 following the inspection to be provided with specified information and documentation by 16 November 2018. We found gaps in the information received.

Recruitment procedures did not ensure the staff employed at the home were suitable to work with vulnerable adults. Before the inspection the CQC received Whistleblowing concerns that staff were working at Glenside Manor without appropriate checks. There were staff known as "agency staff" that were introduced to the provider by recruitment agencies but not directly employed by Glenside Manor Healthcare Services Limited. The HR assistant was not able to show that agency staff recruited were suitable to work with adults at risk. The five staff files we checked did not have satisfactory evidence of previous employment

or the qualifications and skills in caring as required by Regulation 4 Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. We found the recruitment agency provided the written references which meant satisfactory evidence of conduct from the previous employer was not provided.

There were agency staff working across the site including Newton House without the appropriate disclosure and barring checks. Disclosure and barring service (DBS) checks makes sure unsuitable staff were employed to work with adults at risk. Records of DBS checks were not available at the time of the inspection for all agency staff working across locations.

Staffing levels were not maintained by staff employed by Glenside Manor Healthcare Services Limited. 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. The HR assistant told us 240 staff across the Glenside Manor and hospital had left since 2017. There was an expectation from the provider that these agency staff were used to maintain staffing levels.

The staffing list provided included the names of 15 staff with the role of delivering direct care for up to 12 people. The training matrix listed the names of nine staff as having attended training. We found the same names of eight staff in the staffing list and training matrix. The provider information records (PIR) dated 10/07/2018 detailed that 14 staff were employed to deliver the regulated activity and at the time there were five vacancies. This PIR also revealed that a significant number of agency staff were used to maintain staffing levels in the 28 day period before the 10/07/2018.

New staff did not always have an induction to prepare them for the role they were employed to perform. The CQC following this inspection formally requested under Section 64 of the Health and Social Care Act 2008 to be provided with specified information and documentation by 16 November 2018. This information included the names of staff working at the home and the training matrix. The training matrix showed one staff at Newton House was undertaking an induction and the nine staff listed had not attend the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. While the training matrix indicated 99 % compliance with training there were seven names included in the staff list that were not on the training matrix. There was no evidence of the training attended by seven staff included in the staff list but not on the training matrix.

There was an internal induction programme of topics and once complete staff were signed as competent. The training matrix provided during the inspection showed five staff were undertaking this induction. However, there was no evidence in five staff files of the induction completed or in progress. We were informed that not all staff had received an induction or mandatory training due to the level of the English they spoke and understood. It was said that the training staff would be unable to sign these staff off as their English was so poor.

The CQC had not received notification in relation to reportable of incidents of significant risk towards others.

Inadequate

Is the service well-led?

Our findings

At the previous inspection dated 29 and 30 August 2018 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that quality assurance and audit systems were not robust and did not cover all areas of care delivery. We asked the provider following the inspection to tell us how they were going to meet Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection, the provider failed to report on the actions to meet Regulation 12 and 17 of Health and Social Care Act 2008, its associated regulations, or any other relevant legislation. At this focused inspection we found there was continued breach of Regulation 17.

The CQC following the inspection formally requested under Section 64 of the Health and Social Care Act 2008 to be provided with specified information and documentation by 16 November 2018. These documents included audits that measured the quality of service delivery. We also invited the provider to feedback about our concerns and to gain reassurances of improvements in the delivery of care people were to receive.

Quality assurance systems were not effective and there was little evidence that improvements were prioritised. Copies of audits received were not based on the quality of the care delivered but that records were in place. For example, there was a 100 percent compliance met for health monitoring, medicine administration records (MAR), medicine management, equipment and for personal protective equipment (PPE). Care plans review assessed that people had care plan in place for such needs as personal care, communication and mobility. However, the quality of the care plans was not assessed. We were not provided with infection control audits.

The staff did not feel valued and their rights and wellbeing were not protected. We received whistleblowing concerns about the leadership of the organisation. On the first day of the inspection we were told there were no senior staff on duty. The staff we spoke with were distressed about an incident that has occurred the previous day, between the provider and senior managers. The staff told us morale was poor across the six locations as they were in daily fear of losing their jobs, due to witnessing other staff being dismissed daily and subsequently ordered off site. The annual staff survey results provided by the operation's director indicated 50% of staff felt the organisation did not take positive action about their health and wellbeing.

Staff told us that they felt there was a bullying culture at the service and would not be able to raise concerns. The staff told us morale was poor across all locations as they were in daily fear of losing their jobs, due to witnessing other staff being dismissed daily and subsequently ordered off site. We have been made aware that a number of staff do not feel that their employment rights have been protected.

The provider was not able to demonstrate that staff working at the home were suitable to work with adults at risk. During the inspection staff told us there were language barriers, staff were working without appropriate clearances and were not trained to meet people's care. The HR assistant was not able to verify how many staff were working at Glenside Manor or about the clearance checks of all staff known as "agency staff" working across locations.

The provider failed to ensure there were sufficient staff recruited to deliver continuity of care and that agency staff were competent. The managers meeting minutes dated 18 September 2018 listed the staff that were leaving and agency staff being used in all Glenside Manor locations. For example, there was one rehabilitation assistant and one registered nurse that had resigned. Also detailed was that "two senior nurses are looking at handing in their notice." For another location it was stated that "seven staff have left since May 2018."

There were a number of staff on site whose identity could not be confirmed by the most senior staff on duty. We received concerns about staff known as "agency staff" as they were not directly employed by the provider but introduced to the provider by recruitment agencies. Whistleblowers told us senior managers were unaware of staff working and accommodated within Glenside Manor. On the 7 November 2018 we requested a list of all "agency staff" working across Glenside Manor locations. The list of "agency staff" included 30 names. During the inspection CQC inspectors introduced themselves to another 11 "agency staff" which were added to this list. These staff were employed to cover various roles within the Glenside Manor site.

Some "agency staff" were also accommodated within the Glenside Manor site. The provider following the inspection was formally requested under Section 64 of the Health and Social Care Act 2008 to submit a staffing list of staff working across the Glenside Manor locations. The names of 41 "agency staff" were not included in this staffing list or in the training matrix. The minutes of 16 October 2018 meetings also requested by CQC under Section 64 of the Health and Social Care Act 2008 confirmed there was confusion about the personnel living at the Glenside Manor site. The minutes stated that the operation director had requested from the provider "an updated list of staff that live on site, who they are, where they are from and when they arrived."

The provider did not ensure that staff were trained and skilled to meet people's needs. People were placed at risk relating to the health, safety and welfare because staff were not appropriately trained. The provider failed to ensure the staff were trained and competent to meet people's specific needs. For example, tracheostomy and ventilator training.

The maintenance of equipment was not managed safely and placed people at risk of harm. Whistleblowers raised concerns about the competency of maintenance staff working and accommodated at Glenside Manor. Maintenance staff were not qualified to undertake the refurbishments, tests and checks they had been undertaking. The maintenance staff were undertaking checks of fire alarm system, boiler checks and legionella. We formally requested proof of competence or qualifications for maintenance staff to undertake maintenance checks. However, the various ID cards provided did not demonstrate the competence of the maintenance staff. For example, the provider gave us details of the maintenance manager's Construction Skills Certificate Scheme (CSCS) card. This card provided proof of training and qualification for work they were skilled to undertake in a construction site. (The maintenance manager had a CSCS card for construction site operative.) This meant the maintenance manager qualification was for working in a construction site and was only able to support skilled staff in a construction.

We spoke to the maintenance manager on the 7 November 2018 about their competence and were not able to verify their qualification for water safety. This was because the certificate number on the ID card had faded. Due to this we have been unable to confirm that checks have been completed safely. We have referred these issue to a number of other agencies including the fire department.

We formally requested under Section 64 of the Health and Social Care Act 2008 to be provided with specified information and documentation by 16 November 2018. Documents requested included checks of the

Hydrotherapy pool and gas safety checks. The risk assessment for the hydrotherapy pool was not reviewed annually and was last reviewed in 2016. This was despite a chemical incident, in March 2018, during which the police and the fire department were called. The certificates for gas safety checks provided related to catering equipment and not for the gas heating system at Glenside Manor.

People and others were not protected from the risk of harm. The CQC requested reports of incidents and accidents. Whistleblowers told us on the 7 November 2018, the online reporting system known as GEMS was not being monitored because the staff were not assigned to review online reporting of accidents and incidents. We formally requested under Section 64 of the Health and Social Care Act 2008 to be provided with specified information and documentation by 16 November 2018. Documents requested included reporting of accidents and incidents. This was confirmed by the minutes of the managers meetings dated 2 October 2018 provided under Section 64. It was stated that "Managers are not receiving action updates from GEMs now that [name] has left. Currently nobody is reviewing GEMs."

The provider had notified the CQC of some incidents reportable under the Care Quality Commission (Registration) Regulations 2009: Regulation 18. However, not all incidents were reported. The provider failed to report an incident where fire safety services were called to the Glenside Manor site. We were given access to the online reporting of incidents and accidents on the 7 November 2018 and we noted there was a report of equipment failures. However, this incident related to staff not responding immediately to emergency alarms of equipment and reportable under Regulation 18 of Care Quality Commission (Registration) Regulations 2009. Other incidents not reported included theft and medicine errors.

CQC was also told by a whistleblower that staff received lots of complaints and the provider would meet with the families concerned. This whistleblower said complaints "would disappear", so they were not being recorded or dealt with properly. Two relatives in another location told us they had made numerous complaints but a record of these complaints were not documented in the complaints log. For example, concerns about the lack of rehabilitation therapies. A relative told us they made numerous written complaints. This relative said they had an acknowledgement of complaints received but there was no further action from the provider.

This was a breach of Regulation 17 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 Quality assurance systems The provider failed to ensure safe recruitment procedures were in place The provider failed to ensure staff were trained and maintenance staff were qualified for the repairs and system checks they were undertaking. The provider failed to report allegations of abuse and incidents of potential harm The provider failed to inform CQC of events that prevented the smooth running of the home.

The enforcement action we took:

Impose positive conditions