Glenside Manor Healthcare Services Limited

Glenside Farnborough

Inspection report

82 Albert Road
Farnborough
Hampshire
GU14 6SL

Tel: 01252375547
Website: www.glensidecare.com

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Glenside on 13 March and 14 March 2018. The inspection was unannounced. Glenside Farnborough provides residential accommodation and rehabilitation services for up to 22 people with brain injury and / or neurological conditions. At the time of the inspection 21 people were using the service.

At the last inspection, in November 2015, the service was rated Good. At this inspection we rated the service as Requires Improvement. Glenside Farnborough 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 had a registered manager. 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.

The service had a satisfactory approach to safeguarding. For example there was a suitable policy and procedure in place and staff received appropriate training. Where there had been safeguarding concerns, these were reported appropriately, and any recommendations had been implemented.

A risk assessment process was in place. Risk assessments were comprehensive and reviewed regularly. Other records were comprehensive, accurate and up to date.

Health and safety procedures were satisfactory. Equipment was regularly checked and was judged as safe.

Staff received training about behaviours of people which could challenge the service. There were however concerns about how management had responded to some incidents, where staff had felt threatened and did not feel safe.

Some concerns were expressed about staffing levels, and the ability for staff to subsequently provide satisfactory activities and rehabilitation within the current staffing levels provided.

Staff recruitment, training, supervision and appraisal systems were effective, and suitable records were maintained. However records of staff induction could be improved. We have recommended new staff, who have not worked in the health and social care sector previously, undertake the Care Certificate.

Medicines procedures were to a good standard. People received the correct medicines on time. Suitable records were kept. The service was very clean, and there was a good standard of infection control precautions in place.

Assessment processes were comprehensive to enable decisions about whether people were suitable to

move into the service. Care plans were also comprehensive and regularly reviewed. People had some involvement in the care planning process. The service had a suitable approach to assessing people's mental capacity. Documentation about mental capacity was comprehensive.

People had a choice of meals, and were positive about the food they were provided with. We were concerned about some aspects of the support provided; for example whether food was prepared appropriately for those who were at risk of choking.

People's healthcare needs were met by external professionals. However there were concerns about whether satisfactory physiotherapy was provided by the service. This meant that people's rehabilitation was currently not effective as it should be. The registered provider said this would be improved, but people said there had been a problem for some time.

Staff were seen as caring, respectful and supportive. Some people felt frustrated by what they saw as too many rules at the service, and the inability for staff to escort them out of the home if they were unable to go out on their own. People were involved in decision making however, and staff were observed as friendly and attentive.

We had significant concerns about the provision of activities. Although there were records to demonstrate some activities occurred, we received concerns that people did not have enough things to do, that there was a lack of transport available, and there was currently a lack of dedicated staff to provide suitable activities for people.

There was a lack of confidence in the complaints procedure. Although records of complaints management were satisfactory, several relatives we spoke with, said when they had made complaints, improvement had not been sustained. Two relatives said they had given up raising concerns as things did not improve.

Concerns were raised by people and relatives that there had been many changes to the management of the service recently and this had led to inconsistency and uncertainty.

Staff said they thought the team worked well together and the team did their best to ensure people's needs were met. There was a good system of staff handover, and communication within the team.

The service had a comprehensive system of quality assurance to ensure standards were monitored and improved as necessary. However the system had failed to pick up and address many of the issues we have raised as concerns within this report.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see the action we have told the provider to take at the end of this report.

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 entirely safe.

Satisfactory safeguarding policies and procedures were in place. Where there had been safeguarding concerns the service had responded appropriately.

Management did not always provide suitable support to staff if people's behaviour challenged the service.

People's medicines were managed safely

Current staffing levels did not always meet people's needs

Is the service effective?

Requires Improvement

The service was not entirely effective

Suitable assessment procedures were in place so the service could check it could meet their needs before admission was agreed.

Staff received suitable training, supervision and appraisal.

Although people's health care needs were met by external professionals, people's rehabilitation was not supported. The service did not provide appropriate physiotherapy support.

Is the service caring?

Good

The service was caring.

Staff were seen as caring, respectful and supportive.

People had care plans and were involved in their development and review

Is the service responsive?

Requires Improvement

The service was not entirely responsive.

Activities provision was not satisfactory.

There was a lack of confidence in the effectiveness of the complaints procedure.

Is the service well-led?

Requires Improvement

The service was not entirely well led

Management of the service was not stable.

Quality assurance systems were not effective.

The team worked well together and communicated well.

Glenside Farnborough

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.

This inspection took place on 13 and 14 March 2018 and was unannounced. The inspection team consisted of a lead inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience used had experience of using services for people with physical disabilities.

Before the inspection we reviewed information we kept about the service and previous inspection reports. This included notifications of incidents. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern. We also reviewed the Provider Information Record (PIR). The PIR provides key information about the service, what the service does well and the improvements the provider plan to make. We also emailed professionals and relatives of people who used the service to find out what they thought about the service.

During the inspection we used a range of methods to help us make our judgement. This included talking to people using the service, their relatives and friends or other visitors, interviewing staff, pathway tracking (reading people's care plans, and other records kept about them), observation of care practice, and reviewing other records about how the service was managed.

We looked at a range of records including three care plans, records about the operation of the medicines system, five personnel files, and other records about the management of the service.

Before, during and after the inspection we spoke with nine people who used the service, and nine staff. We also communicated, by email or by telephone, with seven relatives of people who used the service. We also communicated with twelve external professionals including specialist nurses, GP's and social workers.

Requires Improvement

Is the service safe?

Our findings

The service had a satisfactory safeguarding adult's policy. All staff had received training in safeguarding adults. The registered manager said safeguarding processes were discussed with staff at team meetings and in supervision sessions. Staff demonstrated they understood how to safeguard people against abuse. Staff told us they thought any allegations they reported would be fully investigated and satisfactory action taken to ensure people were safe. Where necessary the registered provider had submitted safeguarding referrals to the local authority where they felt there was a risk of abuse. An external professional commented in respect to the service's approach to safeguarding, "Given the challenging nature of the client group there is always a likelihood of safeguarding incidents (such as physical or verbal altercations between people). (At Glenside) these appear to be well managed and lessons learned from recent incidents." Another external professional said, "They seem very aware of the risks posed and are managing these appropriately."

People were encouraged to raise any concerns if they felt unsafe. The registered manager said although some of the people living at the service had limited or no verbal skills, staff understood people very well, and changes in behaviours would provide staff with an indication they were unhappy and something was wrong.

The registered manager said no concerns had been expressed about people being discriminated against, which subsequently might amount to abuse or cause psychological harm, for example due to their disability or their gender. The registered manager said all staff were currently undertaking equality and diversity training.

Risk assessments were in place for each person. For example, to prevent poor nutrition and hydration and falls. Risk assessments were reviewed monthly and updated as necessary. Health and safety risk assessments were completed for all areas of the building, as well as tasks which may present a risk.

Some people who lived at the service did not have capacity to make certain decisions and there were some restrictive practices in place to keep people safe. Staff minimised restrictions where possible. For example, if people were able, they could move around shared areas of the building without restriction, spend time in their bedrooms and were encouraged to make a range of choices such as what to wear, what to eat and how to spend their time. The registered manager said where people had limited, or lacked capacity, staff supported them to maximise choice and independence.

Records were stored securely in the office. Records we inspected were up to date, and were accurate and complete. All care staff had access to care records so they could be aware of people's needs.

The registered manager said there were formal handovers between each shift. These enabled staff to share information and concerns about the care of people. We attended one staff handover. There was a comprehensive discussion about people's needs, and consultation between the staff present about how various tasks would be completed. There were also staff meetings to ensure important information was discussed.

The service had a whistleblowing policy so if staff had concerns they could report these without feeling they would be subject to subsequent unreasonable action for making criticisms of the service.

Equipment owned or used by the registered provider, such as specialist beds, hoists, stand aids and gym equipment was suitably maintained. Systems were in place to ensure equipment was regularly serviced, and repaired as necessary. In regard to moving and handling equipment, one of the senior staff was given the responsibility of ensuring visual checks were completed, and ensuring any maintenance was arranged as necessary.

Health and safety checks on the premises and other equipment were carried out appropriately. The boiler, gas appliances and water supply had been tested to ensure they were safe to use. Portable electrical appliances had been tested and were safe. A current gas safety certificate was in place. The electrical circuit had been tested and was deemed as 'satisfactory'. Records showed manual handling equipment had been serviced. There was a risk assessment to minimise the risk of Legionnaires' disease, and systems were in place to take action to minimise the risks identified. There was a system of health and safety risk assessment in place. There were smoke detectors and fire extinguishers on each floor. Fire alarms, emergency lighting and fire extinguishers were checked by staff, the fire authority and external contractors, to ensure they worked. The service had a fire risk assessment.

Each person had a behavioural care plan. This outlined any behaviours which were seen as challenging to the service. Staff recorded all incidents that occurred and these were reviewed by senior staff. Where people regularly demonstrated behaviours which the service found challenging, the service used recording tools such as 'ABC charts.' These outlined what the person was doing before the behaviours occurred, a description of the behaviours, and what happened afterwards. This helped staff to understand the behaviours, and where possible minimise the risk of it happening. All staff were trained in recognise behaviours techniques to help them deal with any behaviours which may put the person, or others at risk. When these techniques were used suitable records were kept.

We did receive some concerns from staff members about their own safety. There had been an incident recently when a member of staff was assaulted by one of the people who used the service. The registered manager dealt with this incident appropriately. However we spoke with another member of staff who said they "Did not feel very safe when I am here," due to one person's behaviours. The staff member said they had reported an incident to team leaders, but had just been told to record incidents in the person's record. The member of staff said they had not been suitably supported following the event. This matter was reported to the registered manager, and the nominated individual, who both said the matter would be addressed. It is important that staff are effectively supported following incidents such as these. Debriefing can provide staff with support and allow services to learn from incidents so improvements can be made to how people are supported.

Other staff also said they had been assaulted, and people could be aggressive due to their health conditions. We were told such behaviours was not always predictable. One member of staff said some staff members could be "Too friendly," with some people. This would include not having suitable professional boundaries resulting in some staff "stroking," or "cuddling," people. As a consequence this created "Mixed messages." The member of staff said the matter had been discussed with management, and such behaviours were less prevalent now, but still did occur.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

In regard to staffing levels, on the first day of the inspection there were nine care staff on duty in the morning, afternoon and evening. Overnight there was four staff on waking night duty. The service also employed cleaning, kitchen, laundry, maintenance and administrative staff to help ensure the service ran effectively. There were two team leaders on duty during the day and one at night. The registered manager worked at the service during the day Monday to Friday. The registered manager said some people required one to one support to keep them and others safe.

The registered manager ensured staff on duty had a suitable mix of skills, experience and knowledge. Any new and inexperienced care staff were always shadowed by experienced staff. All staff were provided with suitable training for example in moving and handling and life support training, so they could meet people's needs and deal with emergencies. If staff were off sick the registered manager said he always ensured, where possible, agency staff were employed, to avoid staff shortages. The service had a list of regular agency staff which would be used so these staff were aware of people's needs and trained accordingly.

Based upon the feedback we received we did have concerns about staffing levels. Staff members we spoke with mostly said staffing levels were satisfactory. However some staff did say staffing levels were not always satisfactory. For example we were told that if staff went out with people, this could consequently affect the rest of the team's ability to carry out necessary duties such as carrying out observations and checks on people. We were also told it was difficult to carry out rehabilitation work correctly due to time pressures. For example, a staff member said if they made a cup of tea for someone this would take a minute or two, but if they worked with the person, so they could make a cup of tea for themselves this would take ten minutes, and although the latter was the correct approach, it was not always possible to do this due to the significant number of tasks staff needed to complete during their shifts. We also received some concerns from relatives. For example we were told: "There are enough staff but only by using agency personnel. The problem is chronic turnover of staff, many barely lasting six months. The consequence is lack of continuity, superficial rapport between staff and patients and not many activities," "It is understaffed for the service users they accommodate," and, "There have been occasions when I have had to search for a staff member. On one occasion the first two members of staff I found informed me they were new and could not help me…(but mostly) staff are supportive and caring."

We recommend that staffing arrangements are reviewed to ensure there are enough staff to assist people with their day to day needs, provide more activities and rehabilitation, and to minimise risk where there are behaviours which challenge the service.

The service had a suitable recruitment procedure. Recruitment checks were in place and demonstrated that people employed had satisfactory skills and knowledge needed to care for people. All staff files contained appropriate checks, such as two references and a Disclosure and Barring Service (DBS) check. New staff were subject to a three month probationary period. Staff performance was reviewed on a monthly basis, followed by a meeting about whether their appointment would be confirmed or not, or their probation was extended. There were comprehensive records to confirm this process.

Staff received effective training in safety systems, processes and practices such as in moving and handling, fire safety and infection control. All staff were trained in fire procedures so they received suitable training about best practice about fire prevention and dealing with emergencies.

The registered provider had a policy in place regarding the operation of the medicines system based on current guidance such as that issued by the Royal Pharmaceutical Society and NICE. Senior staff were responsible for the administration of medicines. These staff had received appropriate training about the operation of the medicines' system. There was a dedicated medicines room which was clean and tidy.

Medicines were given to people at the correct times. Accurate administration records were kept. At the time of the inspection nobody self-administered their own medicines. Suitable systems were in place for medicines which required additional security. The service had effective systems in place to order medicines, ensure they were stored securely in locked, purpose built cabinets, and where necessary disposed of safely. We were concerned that not all creams, drops and lotions were labelled to state when they were opened to be used. This is important because some items can become ineffective after a period of time once opened. The registered manager said he would address this matter immediately.

There were occasions where some people needed to have their medicines administered covertly. The service had suitable procedures about this. These medicines were only ever administered this way with the authorisations from external medical professionals. People's behaviours was not controlled by excessive or inappropriate medicines. Some people did have some prescribed medicines to help them manage distress or confusion, (for example as a consequence of mental health issues) but these medicines were prescribed and reviewed by external medical professionals. When these medicines were prescribed to be given 'as required', rather than at specific times, guidance was in place as to when this should be given. This helped ensure staff took a consistent approach when administering these types of medicine. People had suitable links with their GP's, and medical consultants who prescribe and review people's medicines. Where necessary staff appropriately consulted with medical professionals to ensure types of medicines prescribed, and dosages were helping people with their health needs.

The service had arrangements in place to ensure the home was kept clean and hygienic. The service had suitable policies about infection control which referenced national guidance. The registered persons understood who they needed to contact if they needed advice or assistance with infection control issues. Cleaning staff were employed and had clear routines to follow. All staff had received suitable training about infection control. Staff understood the need to wear protective clothing such as aprons and gloves, where this was necessary.

Care and catering staff had completed food hygiene training. Suitable procedures were in place to ensure food preparation and storage met national guidance. The local authority environmental health department had judged standards as being at a high standard.

The registered persons understand their responsibilities to raise concerns, record safety incidents, concerns and near misses, and report these internally and externally as necessary. We did have concerns that senior staff did not respond appropriately following incidents when people had been physically aggressive towards staff. This matter is discussed elsewhere in the report. The registered manager said if he had concerns about people's welfare he liaised with external professionals as necessary, and had submitted safeguarding referrals when he felt it was appropriate.

Since the last inspection, there had been a series of safeguarding meetings about the care of some of the people who had used the service. The registered manager said the service had learned from the concerns raised. Key learning points had been shared with staff within the service. The registered persons had participated and been fully co-operative when there had been external investigations for example about safeguarding matters.

The service kept some monies on behalf of people. People received suitable assistance if they needed help purchasing items. Clear records were kept of expenditure and receipts were obtained. The registered manager had overall responsibility for checking monies held, and records kept were accurate. The registered persons did not act as appointee for any people who used the service, and staff did not have any access to people's financial accounts. This demonstrated systems for keeping people's monies safe were

robust.

Requires Improvement

Is the service effective?

Our findings

The service had suitable processes to holistically assess people's needs and choices. Before moving into the service the registered manager told us he went out to assess people to check the service could meet the person's needs. Copies of pre admission assessments on people's files were comprehensive. Relevant reports were obtained from other agencies to assist with the assessment process and to help the service to decide if they could meet the person's needs. Assessments assisted staff to develop a care plan for the person so care was delivered in line with current legislation, standards and guidance. People and their relatives had the opportunity to visit the service, before admission was agreed, to check they would like to come to live at Glenside, and also ask any questions.

Nobody we spoke with (for example people who used the service and staff) said they felt they had been subject to any discriminatory practice for example on the grounds of their gender, race, sexuality, disability or age. The registered persons' had an anti-discrimination policy, but this currently only covered staff. The registered manager said this would be reviewed so it covered people who used the service.

The use of technology and equipment to assist with the delivery of effective care, and promote people's independence was limited. There was however a call bell system which people could use to alert staff in emergency. We observed staff responding to call bells promptly. The people we spoke with said they did not have any concerns about staff responsiveness to call bells.

Staff had appropriate skills, knowledge and experience to deliver effective care and support. The registered manager said when staff started working at the service they received a full induction. This involved spending time with a senior member of staff, and then shadowing more experienced staff to learn their roles. New staff attended a one week induction at the registered provider's head office. This was followed by a two week period when they shadowed experienced staff at Glenside. The registered manager said he was aware of the Care Certificate, which is an identified set of national standards that health and social care workers should follow when starting work in care. Currently the registered manager said none of the staff completed the Care Certificate. We inspected records of the induction process completed for some of the staff who had commenced employment in the last year. The only records we saw were an orientation checklist which was completed when staff started work at Glenside. There were no records to confirm staff had completed the formal induction at the registered provider's headquarters, or the staff had completed shadow shifts. However the staff we spoke with said they thought they had received a thorough induction.

Staff members we spoke with said the induction they had completed was a good experience, but they had no knowledge whether they had been offered to complete the Care Certificate, or what it was.

We recommend that the registered persons ensure all staff who have no experience of previously working in adult social care, complete the Care Certificate. Records to show staff completed staff induction should also be improved and filed on staff records.

Records showed staff received comprehensive training which enabled them to carry out their roles. For

example all care staff had a record of receiving training about techniques to manage behaviour which challenged the service (MAPA), first aid, fire safety, infection control, moving and handling and safeguarding.

Staff told us they felt, on the whole, supported in their roles by colleagues and senior staff. There were records of individual formal supervision with a manager. Supervision is a process where members of staff sit down with a supervisor to discuss their performance, any goals for the future, and training and development needs. There were records that staff who had been post for at least a year had received an annual appraisal. The staff we spoke with said they could approach senior staff for help and support if they had a problem. There was always a senior member of staff who staff could approach if they needed help. Senior carers were also responsible for leading all shifts and ensuring the effective day to day management of the service, particularly if the registered manager and deputy manager were absent from the service.

The service had a weekly menu. At breakfast time people could have cereal and /or toast. People had their main meal at lunchtime. At tea time a light meal was prepared such as a sandwich or beans on toast. People could have snacks and drinks at other times during the day and evening. Meals were generally prepared by catering staff. However some people were encouraged to do some food shopping, and also cooked for themselves with assistance from staff. The registered manager said there had been some difficulties encouraging people to participate in rehabilitation plans to shop and cook for themselves. This was because, even if people had their own kitchen facilities, it was easy for them to have a main meal in the dining room. The registered manager said staff were going to try and address this matter, as if people did not engage in the process to cater for themselves, it made the process of helping people to move on to become more independent more difficult to achieve.

Some people who used the service had specific cultural or religious preferences about the food they ate. Some people also had special diets, for example diabetic or gluten free diets. Some people were vegetarian. The registered manager said these people were catered for accordingly.

The registered manager recognised that meals were an important part of people's day. The current menu provided a balanced diet which promoted healthy eating and correct nutrition. Meals were appropriately spaced and flexible to meet people's needs.

Some people needed assistance with eating their meals. For example, some people needed someone to sit with them and help them to eat. People had eating and drinking assessments in their files. Assessments outlined relevant risks for example malnutrition, dehydration and choking. However from feedback we received it was clear staff were either unaware of the guidance or were not supporting people in line with their care plans.. For example, some people required food to be cut up, pureed or mashed. However, we received two comments from relatives that this was not always done, and this put people at risk of choking.

We observed the lunchtime period. Staff provided people with suitable support, during the observation period, for example one to one support. The meal time was unrushed. When people needed support staff sat with people to help them. We had a meal which was appetizing and nicely cooked.

We were told that people were given a choice of two meals. People were asked at the beginning of the week to choose their meals for the week. As some people had memory problems, it may have been difficult for them to remember choices they made so far in advance. There did not appear to be any current arrangement where people could make a more informed choice on the morning of the meal, or just before the meal was served.

We recommend arrangements for making choices about meals are reviewed. For example to ensure people received appropriate support if they were at risk of choking, and people to be offered a choice of meal nearer to the time of the meal itself so they could make a more informed choice of what they wanted to eat.

Some concerns were raised about the lack of regular physiotherapy available. For example, one person, who had lived at the service for a few weeks, said they had not received any. They told us that, as a consequence they, "were not making enough progress," and were not getting the support they needed to improve their abilities. Other comments included: "I need physiotherapy as I need more exercise to help with walking. They don't have the right equipment so I don't feel safe to do it on my own," and "I'd like more physio but don't want to make a fuss. I want to go out more, walk more, but staff don't have the time."

Relatives also raised concerns that there was not enough physical rehabilitation available and that any rehabilitation provided lacked structure. For example we were told, by relatives people did not have clear plans to help them improve their abilities, and care in place did not seem enough for people to assist them to improve their abilities. We were told, "It is a neurological rehabilitation centre, but there seems to be little done in that respect (with our relative)….there is only a visiting physio one day a week." The registered persons' said physiotherapy and rehabilitation support would improve with the employment of new personnel. However people who used the service, and their relatives said there had been significant problems with support for some time.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

The registered manager said the service had good links with external professionals. The service worked closely with a wide range of professionals such as speech and language therapists, community nurses, dentists, chiropodist's, social workers, opticians and general practitioners to help ensure people received suitable healthcare support. We were told; "I've been to see a chiropodist," and "If I don't feel well, I ask if I can see a doctor if I can." Where staff had concerns about somebody's welfare the service had good links with professionals to ensure any changing needs were reassessed, and they received specialist help as necessary.

The registered manager said relationships with local GP surgeries was good. Where appropriate, referrals were made for additional support from these professionals and others such as occupational therapists, and speech and language therapists. The registered manager said he felt referrals to external professionals were actioned in a timely manner, and there were no significant delays in people subsequently receiving support.

Staff ensured people's day to day health care needs were met. Many people had limited capacity, so if there was significant decisions needing to be made about people's health care needs such decisions were made through the best interest process, and /or in liaison with the person's power of attorney (if the person had one).Records were kept of health care appointments.

The service was situated in a large, spacious two story building. There were two lifts connecting the floors. The building was divided into two main living areas: the main house, and an area for three women. Living accommodation consisted of the main shared house, five self-contained one bedroom flats, and four self-contained studio flats. The service had several lounges which people could use. There was a gym with exercise equipment. There was a dining room, and an activities room. There was a residents' kitchen area where people could prepare snacks and drinks. There was a large garden which people could use. One person also had a personal garden area as they enjoyed gardening. There was staff only areas such as a general office, and a dedicated medicines room.

The building was suitably adapted to meet the needs of people living there. For example the ground floor was accessible to wheelchair users. Recently one bathroom had been refurbished. A bath had been replaced with a shower to accommodate the needs of one person.

Outside areas were accessible to wheelchair users. Everybody had their own bedrooms. There was suitable shared space such as lounges situated around the building. The building was clean and well decorated.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Some people living at Glenside did not have capacity. Where necessary applications to deprive people of their liberty had been submitted. Where DoLS applications had been authorised suitable care plans had been put in place.

Each person had a mental capacity assessment on their files. Copies of DoLs applications were also on people's files, along with any approvals received. The registered manager said he had a system for monitoring DoLs authorisations to ensure they were implemented, and reviewed before any expired. Where it had been necessary to have a best interest process to make decisions about a person's care, for example to decide how DoLs decisions would be implemented, records of these meetings were on file. Staff had received training about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Good

Is the service caring?

Our findings

We received many positive comments about the attitudes of staff. Staff were seen as people who would listen to people's problems, and help to solve them when necessary. One person said, "I like everyone," "Staff are pretty good. If they can help they will." "Staff are very respectful." The majority of people and their relatives said people were treated with respect and dignity. One person said: "Staff are very good if I am down or sad. They give me time and try to understand." Relatives also said staff were polite and helpful. For example we were told "Staff are extremely good, supportive and caring." External professionals said staff were "attentive and responsive…encouraging and praising them as necessary…clients have a good rapport with staff and interact well with them", "Very caring," and, "The staff seem to work very hard and there is always a lot of interaction with the residents. People are taken for walks and sit and chat with people." The staff we spoke with said they thought the standard of care at the service was for example "good."

Some people complained there were "lots of rules" at the service. For example "There are too many rules. Some have to be, but some are annoying."

Care plans contained some information about people's preferences, personal histories and backgrounds. This assisted staff to know the people they were caring for and supporting.

When people came to live at the service, the registered manager gave a life history questionnaire to relatives, and requested it was completed. This way staff could have information about people's lives before they lived at the service. People's key workers also discussed the care plan with them, and consulted with them about its contents.

People were encouraged to make decisions about their care, for example what they wished to wear, what they wanted to eat and how they wanted to spend their time. There was some involvement of people in care planning and review. One relative commented, "My relative has a care plan he was involved in the planning of. We were not involved and staff have not gone through it with us. We have read (our relatives) copy." However due to people's capacity involvement was often limited, and in some cases consultation was also required with people's representatives such as their relatives.

We did not see staff rushing or ignoring people. Staff took time to listen to people, and give people time to respond to questions. Staff appeared friendly. We observed staff making sure people's privacy and dignity needs were understood and always respected. Where people needed physical and intimate care, for example if somebody needed to change their clothes, help was provided in a discreet and dignified manner. When people were provided with help in their bedrooms or the bathroom this assistance was always provided behind closed doors. We did not witness staff talking about people in front of others, and written information was stored confidentially.

Requires Improvement

Is the service responsive?

Our findings

Everyone who used the service had a care plan. Where possible people, and their representatives, were consulted about people's care plans and their review. One person told us: "They have talked about my care (with me). It is about doing things for myself." Care plans were detailed and included information about people's physical and mental health care needs and information about their lives before living at the service. Care plans also included risk assessments, for example in relation to people's mobility, and any risks in relation to eating and drinking. Care plans outlined people's preferences, interests and aspirations. All staff were able to access people's care plans which were stored in the staff offices. The registered manager said review meetings occurred twice a year. External professionals, involved in the person's care, were invited to the meetings to discuss the person's progress. A professional described care plans and risk assessments as, "detailed and personalised…accurate, and needs well documented and understood."

People had opportunities to be involved in some activities. The registered manager said there were currently no group activities organised . Activities were organised for people on an individual basis according to individual needs and preferences. Some individuals participated in activities such as using the gym in the town, horse-riding and guitar lessons. People also went on social activities such as bowling, cinema and going to the zoo. As part of people's care plan some people participated in completing their food shopping. Glenside had just acquired a pool table which relatives had purchased.

The service had a therapy assistant post but this was currently vacant. An activities person, who was self-employed, worked at the service one day a week. Arts and craft activities and Tai Chi sessions were organised.

The registered manager said none of the people were interested in participating in organised religious services.

Some concerns were expressed about transport provision at the service. The service had a vehicle but we were told this was mostly used for medical appointments. Some of the people, who used the service, could use taxis, and other public transport such as buses and trains. Some people had bus passes. However some people were restricted from using public transport due to their disabilities. A relative told us the service used to have a larger minibus. We were told due to the limited availability of transport provided, by the service, this limited the opportunity for some people to participate in the community. One person also said, "They need more drivers," as sometimes the lack of staff with this skill prevented activities occurring.

People expressed concerns about the activities available. We received several comments that in recent years there had been less activities available to people compared to the past. For example we were told there was a lot more activities in the past such as cooking, arts and crafts, and entertainment but this did not happen now. We were told: "There is nothing to do." Relatives told us, "Residents are unhappy, they are bored there is very little rehab or activities."

People told us, "I feel safe but trapped. I go out but I am always accompanied if I go to buy food or to the

pub," "I feel safe but I'd like to go out more. Staff don't have time and I am not allowed out on my own." We received several comments from professionals and relatives where people had told them that they were "Bored," "Trapped," and, "Want to go home."

We were concerned about the activities provision for one person. The person only had structured activities which had been organised by their family. The person's care plan said they should have a walk either within the building or in the park each day. There was a record this occurred most days. The registered manager said the person was not interested in engaging in other activities. However family members said if the correct support was provided the person would participate. The registered provider had commissioned a psychologist to ascertain the person's interests and abilities. The report clearly stated the person would engage in activity and recommended they received more one to one support. The person was often in their flat alone, and the door had to be locked. This was due to the risk presented to the person by other people who used the service. Although staff were scheduled to provide regular checks, a member of staff was not present in the flat with the person. The person lacked capacity. The person's relative said as a consequence of the person not having enough support they were "Isolated and shut away."

Another person said they received, "No input from Glenside," in regard to activities provision. They said any activities were organised by their family or themselves. Several relatives also expressed concerns about lack of activities.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

Some of the people at the service could not read or had limited literacy skills. Some people lacked capacity and could not understand written documentation. Some information provided to people was provided in pictorial form. Otherwise, when people received correspondence, staff read this to people.

The service had a complaints procedure. This was given to people as part of the service user guide, which was issued to people when they moved into Glenside. People and their relatives said if they had any concerns or complaints, they felt they could discuss these with staff and managers. However some people's representatives were not happy with responses to concerns they had raised with the registered persons. They said when complaints were raised any subsequent changes to how care was delivered were not sustained. For example one relative had complained that staff did not always complete regular checks which were required as part of someone's care plan. Incidents which occurred as a result of this had led to a safeguarding enquiry. However, there had been further instances where the person was not checked which had meant incontinence pads were not changed as often as they should have been. The person would become very anxious if staff did not support them appropriately. The relative alleged the frequency of checks had lapsed the day before the first day of the inspection, resulting in them having to use the call bell to ask staff to provide suitable assistance. Some relatives said they did not think it was worthwhile trying to complain as things did not get any better even if they had received reassurances they would. For example several relatives complained about activities provision, and they said this matter had been raised several times with different registered managers, as well as nominated individuals. The service had a record of any complaints made, and a record of how these had been responded to. Overall we judged the complaints procedure was currently not effective.

This is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had been in post since March 2017. He told us that, during the time he had managed the service, he had spent a significant amount of time to bring about improvement to the service. The registered manager said many of the people who had previously used the service had not been appropriate for it, and there had been a process of resettling people to more suitable placements. There had also been a process of refocusing the service as the registered manager thought it had lost its focus of being a rehabilitation service. The registered manager said that now the service had a better mix of people who would live at the service on a long term basis, and people who were using the service for rehabilitation purposes only. The registered manager also said he had reorganised the building. For example, many of the small lounges had previously been used as storage. Now these areas were used for their intended purpose, so people had more space and did not have to always sit together. The gym equipment was now in a more central area and this had resulted in it being used more regularly.

The registered manager told us that previously the role of staff had been to 'help' and 'care' for people rather than to 'enable' people. They were attempting to change the 'mind-set' of staff and in turn reduce people's dependency on staff. The registered manager said he wanted the promotion of independence to be a primary objective of the service. They also had plans to improve activities for younger people who used the service, and also to reduce staff turnover which he saw as problematic.

The registered manager spent time within the service so he was aware of day to day issues. He said he believed it was important to spend time listening to staff and enabling them to share ideas about people's care. The registered manager said he met regularly with staff both informally and formally to discuss any problems and issues. There were handovers between shifts so information about people's care could be shared, and consistency of care practice could be maintained. The registered manager said he also ensured there were regular team meetings.

Glenside Care was purchased by the Raphael Hospital Group in 2017. The registered manager seemed to have a good understanding of his responsibilities. The service had a clear management structure. There were always team leaders who ran the shifts, and they were responsible to the registered manager. The registered manager said he ensured there was always a team leader on duty during the day.

Staff we spoke with said they were positive about the registered manager. People told us, "The manager is brilliant. He comes (to see me) every day." Staff described the registered manager as "Brilliant," "Nice," "I have a very, very good relationship with him," and "He is okay." Most relatives were positive about the registered manager, although some said he was "Office bound," and they did not see him much. Another relative said, "Management is poor, there is a distinct lack of communication, very little continuity and consistency. "External professionals described the registered manager as, "Very helpful towards supporting residents. His ethics are spot on and he has always worked in my clients best interests. He really listens at review meetings, and is prepared to go the extra mile to help and assist."

Within several days of the inspection we were informed by relatives the registered manager was no longer

working at the service. It was confirmed by the nominated individual that the registered manager had left, and been replaced by another employee of the organisation. We received some comments from staff that they were upset by this decision. Some relatives were also concerned it would result in further change, and a break in continuity. The nominated individual said other relatives had been pleased by the change in management due to concerns raised to the registered provider about some aspects of the operation of the service.

Staff we spoke with said they worked well as a team. Staff said they and communicated well. Staff appeared to have a good understanding of their responsibilities. Staff said all staff and told us they shared the work load well between themselves. The organisation had suitable processes in place for staff to account for their decisions, actions, behaviour and performance such as a supervision system, and grievance and disciplinary processes.

The registered manager said both paper and electronic data was stored securely, and there were systems in place to ensure data security breaches were minimised.

The registered provider had a 'Quality Strategy,' and 'Quality Improvement Plan,' which helped to ensure the service met organisational and regulatory standards, and improvement occurred when it was needed. This outlined the service's approach to audit and quality monitoring. Quality was measured through a series of audit systems for example of the medicines system, infection control, care planning, health and safety. The service also had a system to survey relevant people to check they were happy with the service provided. People who used the service and their relatives were, for example, surveyed annually. The results of the most recent survey had been positive. The organisation also had a Quality and Governance Committee to monitor any action plans were being implemented. There was a record of some meetings for people who used the service. The registered manager said the last meeting occurred in November 2017. There had been relatives' meetings in the past but these were currently not happening. Some of the relatives we spoke with said it would be good if there was more consultation with them, and their relatives who lived at the service.

However we were concerned that the registered persons' approach to ensuring service quality and monitoring the service was not working effectively or bringing about improvement as necessary. Quality systems had failed to pick up, or address the issues we have raised concerns about in this report. This includes concerns about staffing levels, the provision of meaningful activities, identifying and addressing complaints, providing person centred care designed to meet people's needs and preferences and the provision of effective rehabilitation programmes.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

The registered manager said relationships with other agencies were positive. Where appropriate the registered manager said he ensured suitable information, for example about safeguarding matters, was shared with relevant agencies.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Physiotherapy and physical rehabilitation services were not satisfactory. Activities provision, and arrangements for people to go out were not satisfactory

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints People and their representatives did not think the complaints procedure was effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not effective at detecting problems at the service and ensuring and sustaining improvement

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always provided with suitable and appropriate support after incidents involving people who used the service.