The Glenside Hospital for Neuro Rehabilitation

Quality Report

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Date of inspection visit: 8 November 2018
Date of publication: 01/03/2019

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

The Glenside Hospital for Neuro Rehabilitation is operated (since August 2017) by Glenside Manor Healthcare Services Limited. The Glenside Hospital for Neuro Rehabilitation is an independent healthcare organisation which provides different levels of care to patients with an acquired brain injury.

The hospital service is split into two sections, the neuro-rehabilitation unit (NRU), and the neuro-behavioural unit (NBU). NRU includes three wards; Avon, Bourne and Wylye (27 beds total), each one led by a senior clinical nurse and a consultant in rehabilitation medicine and rheumatology. These wards could accommodate patients with complex nursing needs, providing physical and cognitive rehabilitation, tracheostomy management and weaning, and nutritional management. The wards have single rooms with ensuite bathroom facilities, which are used for male or female patients.

The NBU is run as a single 14-bed service, including two wards Ebble and Nadder, and led by a senior clinical

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nurse and a consultant in neuropsychiatry. The NBU focuses on neuro behavioural interventions which aim to control, reduce and eliminate challenging behaviour, and admits patients detained under the Mental Health Act 1983.

Based in Salisbury, the hospital serves the South West, and takes referals from across the country. On the same hospital complex there are also seven adult social care services. Each service is registered separately with CQC, which means each site on the main complex has its own inspection report.

While each of the services are registered separately, some of the systems are managed centrally, for example, maintenance, systems to manage and review incidents and systems for managing medicines. Physiotherapy and occupational therapy staff cover the whole complex and all services. Factilities such as the hydrotherapy pool are also shared across the whole complex.

We carried out an unannounced focused inspection on 8 November 2018. The inspection was prompted by whistleblowing concerns and information of concern shared with us through intelligence monitoring and system partners. We looked at some elements of safe, effective and well led, and did not rate the service at this inspection.

At the time of our inspection, the CQC adult social care inspection team were undertaking a comprehensive inspection of social care sites, which provide a range of services to complement the neurorehabilitation and the neuro-behavioural pathways. These will be reported on separately although all reports will share some themes around those systems that are centrally managed.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

We found areas of practice that require improvement in services for people with long-term conditions:

- The service provided mandatory training in key skills to staff but did not make sure everyone completed and understood it. We were not assured there were adequate systems and processes in place to monitor or evaluate mandatory training, or to follow up areas of low compliance.
- There were not robust systems and processes in place for safeguarding or that all staff understood how to protect patients from abuse.
- Infection risks were managed inconsistently and were not being monitored.
- The environment and maintenance of equipment was not managed safely and placed people at risk.
- Staff did not always complete and update all relevant risk assessments for each patient, or take action to ensure patients were appropriately placed or their physical and rehabilitation needs were fully met. They did not always keep clear records or ask for support when necessary.
- The service did not have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff did not always keep accurate records of patients' care and treatment. Records were not all up to date or truly reflective of the patients' needs.
- The management of medicines at the hospital was not safe and there were problems with the supply of medicines into the service. There was no clinical pharmacy oversight or service to support medicines management which increased the risk of errors.
- The service did not manage patient safety incidents well. Staff recognised incidents but did not always report them appropriately. Not all incidents were reported or investigated and lessons learned were not shared with the whole team or the wider service.
- The service did not monitor safety effectively or use results well. Staff did not routinely collect safety information across all wards, or share it with staff, patients and visitors. We found no evidence to show managers used this to improve the service.
- The service did not have systems and processes to make sure staff were competent for their roles. Some training in specific skills for roles was provided but managers did not ensure these were attended by all staff.
- Not all staff understood their roles and responsibilities under the Mental Capacity Act 2005 or deprivation of liberty safeguards (DoLS). Patients

Summary of findings

described as lacking capacity to consent to admission and treatment did not have an assessment of their capacity recorded. Legal processes for detained patients were not adhered to.

- Leaders of the service did not have the right skills and abilities to run a service providing high-quality sustainable care.
- The service did not have a vision for what it wanted to achieve or workable plans to turn it into action. Staff, patients, and local community groups had not been involved in developing a shared vision for the service.
- Managers across the service did not all promote a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service did not systematically improve service quality or safeguard high standards of care by creating an environment for excellent clinical care to flourish.
- The service did not have good systems to identify risks, plan to eliminate or reduce them, or cope with both the expected and unexpected.
- The service did not demonstrate a commitment to improving services by learning from when things went well or wrong, promoting training, research or innovation.

However, we also found the following examples of good practice:

- The quality of some nursing care plan updates was of a good standard, and in particular, those of the psychologists were comprehensive.
- Medicines were stored securely in locked cupboards that were accessible only by the key holder or nurse in charge.

Following the inspection, CQC 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 requested further information from the unit manager to be provided by 30 November 2018. We received some of the information requested but not all.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with 22 requirement notices. Details are at the end of the report.

Full information about our regulatory response to the concerns we have described will be added to a final version of this report, which we will publish in due course.

Nigel Acheson

- Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long term conditions		The hospital provided services for people with acquired brain injury. This was a focussed, unannounced inspection. We looked at safety and well led and part of effectiveness for this service. We did not rate this service.

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Background to The Glenside Hospital for Neuro Rehabilitation

The Glenside Hospital for Neuro Rehabilitation is operated by Glenside Manor Healthcare Services Limited. The Glenside hospital came under new ownership in August 2017. The current company owner provides similar services at other locations in the South, and collectively they are known as the 'Raphael Group of Hospitals'. These additional locations were not inspected as part of this inspection.

At the time or our visit the registered manager had been in post at Glenside Hospital since 8 February 2018. 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 was registered with the Care Quality Commission (CQC) for the following regulated activities:

Treatment of disease, disorder or injury. Since May 2011.

Assessment or medical treatment for persons detained under the Mental Health Act 1983. Since April 2012.

Diagnostic and screening procedures. Since May 2011.

The service was previously inspected in June 2016 when it was under different ownership; at that time the inspectors rated the effective, caring, responsive and well-led domains as good, and the safe domain was rated as requires improvement. In August 2017 the service had come under new leadership and now formed part of the Raphael Hospital group. We did not rate the service at this inspection because it was a focused inspection, which means the previous 2016 ratings will remain unchanged at this time.

We carried out a focused, unannounced inspection on 8 November 2018 to follow up on concerns that had been raised with us, and we looked at elements of the safe, effective and well led domains. At the time of our inspection, the CQC adult social care inspection team were undertaking a comprehensive inspection of social care sites, which provide a range of services to complement the neuro-rehabilitation and the neuro-behavioural pathways. These will be reported on separately although will share some themes around those systems that are centrally managed.

Following the inspection CQC 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 requested further information from the unit manager to be provided by 30 November 2018. We received some of the information requested but not all.

Our inspection team

The inspection team was led by an inspection manager, Julie Foster and overseen by the Head of Hospitals Inspection, Mary Cridge. Our inspection team included two hospitals inspectors and was supported by inspectors from the CQC medicines and mental health teams, and a mental health act (MHA) reviewer.

Information about The Glenside Hospital for Neuro Rehabilitation

Before the inspection, we reviewed all the information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us. We liaised with CQC colleagues in the adult social care directorate, and we held information sharing calls with regulatory system partners. We also reviewed information from whistleblowers and relatives of patients.

Summary of this inspection

During the inspection we visited all five wards, looked at the quality of the ward environment and observed how staff were caring for patients; we spoke with the leadership team, three staff who identified themselves as ward managers and other staff members, including nurses, healthcare assistants, therapists and administrative staff. We also spoke with the registered clinician responsible for detained patients. We spoke with five patients and two relatives.

We looked at a selection of six care and treatment records of patients, four care records in depth, and we reviewed a further six sets of records for detained patients. We reviewed a range of policies, procedures and other documents relating to the running of the service. We requested a range of information following the inspection as detailed above, and some but not all information was provided, as set out in the report.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Long term conditions

Safe	
Effective	
Well-led	

Are long term conditions safe?

Safe means the services protect you from abuse and avoidable harm.

Mandatory training

The service provided mandatory training in key skills to staff but did not make sure everyone completed and understood it.

- The service provided training for staff in key skills which were mandatory. Attendance rates were compiled on an excel spreadsheet. The range of subjects included the following: fire awareness, manual handling, health and safety, infection control, safeguarding adults, mental capacity and deprivation of liberty, mental health act, MAPA (management of actual or potential aggression), BLS (basic life support) & AED (automated external defibrillator), first aid, food hygiene, information governance and rapid tranquilisation.
- We asked for, but were not provided with information about how the service determined which staff should receive which training. There were some gaps against members of staff on the monitoring spreadsheet, for example, not all relevant staff were recorded as requiring basic life support training, first aid, catheter care, information governance, prescriptions and safe administration of medicines or mental health act training.
- The spreadsheet did not record mandatory training for medical staff or agency staff. We asked the provider for this information but it was not supplied. Therefore we could not be assured that all relevant staff were up to date with mandatory training. There was no formal process to ensure all staff, including new starters, were captured on the spreadsheet. Senior managers we spoke to could not confirm the spreadsheet was fully up to date.
- The provider set a target of 90% against mandatory training for staff. Information provided to us showed overall good compliance at or above 90% for qualified nursing staff as of November 2018. However, not all qualified nursing staff had attended mental health act training (60%), MAPA training (88% on NRU), basic life support (86% on NRU) and (67% on NBU).
- Allied health professionals achieved an overall mandatory training compliance of 87% and regular bank staff 86%, however, these figures were not broken down to show which training sessions had been missed.
- There were no systems and processes in place to monitor or evaluate training needs or effectiveness, or to follow up staff or departments with low compliance. The provider did not supply any training data for medical staff or leaders at the hospital as requested, and we were unable to ascertain how this was being monitored as they were not included on the training spreadsheet. We were told by senior managers during the inspection there was not an annual training report, or review or training data.
- Training was not delivered in a way all staff could understand. This was because training was delivered to staff in English and many of the new agency staff had poor understanding of the English language. English language sessions were provided for staff but we were told were poorly attended. Staff whose first language was not English were expected to achieve a certain level of English language before they progressed past their probation period. We saw concerns had been raised by the training lead and documented in the minutes of the senior management meetings on two occasions; the concerns related to the ability of the non-English speaking staff to understand the training on offer, but no action had been taken.
- Staff were not being signed off as competent for their roles. Some staff raised concerns about effectiveness of training for agency staff. We were told of observations of rough handling by staff with patients. This had been raised by staff using the electronic reporting system and at team meetings. Actions agreed as a result were to promote good manual handling by observation and having a competency signed off by the health and safety lead. However, we were told this was not happening

because the health and safety lead had recently left their post. We asked for evidence of competency packs, and evidence of staff being signed off as competent, but this was not provided.

- There was a rising trend in the need for physical intervention to maintain the safety of patients and staff. The data showed that between January and April 2018 there had been between one and six interventions recorded in a month. From May to November 2018 there had been between six and 18 interventions in a month. We did not see this trend discussed at managers meetings or escalated as a concern.
- The provider was not taking sufficient steps to ensure all staff had completed their training (MAPA) on how to manage behaviour and prevent physical interventions. Although most staff we spoke with told us they understood the techniques to manage behaviour and prevent physical intervention, not all staff likely to be involved in managing patient behaviour had been trained, for example only 88% of qualified nurses on NRU. In addition, not all relevant staff were recorded on the training spreadsheet as requiring this training. We reviewed one serious incident where two of the three staff involved had not been MAPA (management of actual or potential aggression) trained, but were using MAPA techniques and this had resulted in a serious injury to a member of staff.

Safeguarding

There were not robust systems and processes in place for safeguarding or that all staff understood how to protect patients from abuse.

- The provider did not monitor adult safeguarding training compliance for all members of staff. The service provided information to demonstrate staff received mandatory training on safeguarding vulnerable adults at induction and as a yearly refresher. Attendance figures provided by the service showed 100% staff compliance with training. However, these figures did not include medical staff or senior leaders. In addition, the information provided did not identify what level of safeguarding training had been provided, and the service did not offer training for safeguarding children.
- The service did not offer training for safeguarding children. Minimum training for safeguarding children for both clinical and non-clinical staff are set out in the 'Safeguarding children and young people: roles and competences for health care staff intercollegiate document: March 2014.' This requires that all staff working in health care settings require level 1 training, and all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers require level 2 training.
- Roles and responsibilities for safeguarding were not clear. We were unable to identify any staff who had received higher level training for safeguarding vulnerable adults and it was not clear from talking with senior managers who had responsibility or oversight of safeguarding, or where it was monitored or reported. We requested job descriptions for the managers but these were not provided.
- There were not formal systems and processes in place to manage safeguarding concerns. Most staff we spoke with could describe situations that might cause them safeguarding concerns and told us these were referred to the local authority for assessment and further investigation where necessary. Staff we spoke with were conscientious in ensuring safeguarding concerns were reported and checked with managers they had been sent. However, we found there to be a reliance of verbally checking safeguarding referrals had been made, particularly over the weekend when information had to be passed over to staff on duty, as reporting was not possible out of working hours.
- During the inspection, we were made aware of an incident that should have been reported as a safeguarding incident, but had not. CQC colleagues from adult social care made the necessary referrals at that time. This suggested not all staff were able to readily identify the need for safeguarding referrals to be made.
- The hospital had an induction policy for new staff including agency staff which was not always followed. There was also a system for staff to undergo checks with the disclosure and barring service (DBS) but this was not always followed. This was to provide assurances about the risk new staff may pose to patients from a previous criminal record. Newly recruited agency staff were often provided by an agency who recruited from other countries; the provider was responsible for ensuring the DBS checks were completed. We reviewed the files for all substantive staff and found there to be DBS checks in place, and in order, however, we were not able to locate

the files or evidence of DBS checks for agency staff. We raised this with the owner during the inspection and subsequently, however, we were not provided with the evidence requested.

Cleanliness, infection control and hygiene

Infection risks were managed inconsistently and were not being monitored.

- Infection control was not always managed appropriately. On the day of our inspection, the ward areas appeared visibly clean, airy, and free from any unpleasant odours, and we saw staff adhered to infection control principles. Staff and patients had access to hand wash and hand sanitiser on the units and staff received training in infection prevention. However, there were no cleaning logs and staff could not tell us what the cleaning schedules were. During the inspection we were not able to determine when the ward areas had last been cleaned.
- We received whistleblowing information suggesting cleaning was not being carried out at regular intervals, and we heard from ward staff there was not always time to follow correct decontamination procedures, for example wiping down hoists between patients, particularly at times of low staffing. One patient told us "cleanliness was lacking and days would go by without my room being swept or mopped and bedding and towels were not changed". We also heard from the relative of another patient that essential supplies were frequently not replaced on time, for example toilet rolls and towels.
- Staff were able to tell us how they managed infection risks, but also said at times, not all staff followed correct procedures. This was supported by a patient who told us staff did not always wear gloves or aprons or change them when moving between patient rooms. We saw evidence during our inspection that equipment was marked as having been cleaned and we saw staff using correct personal protective equipment (PPE) such as gloves and aprons. We did not find any evidence suggesting a lack of provision of toilet rolls or towels.
- The provider did not have oversight of staff compliance with hand hygiene. We requested results of hand hygiene audits for the previous six months undertaken on the hospital wards and were sent results of an audit completed in April 2018 which showed that staff were 100% compliant with hand washing key moments and hand washing technique in the neuro-rehabilitation wards. The hand hygiene audit had only been completed once during the last 12 months and had only observed five members of staff in total. We did not consider this to be sufficient assurance of compliance oversight.
- The provider did not have oversight of staff compliance with PPE. We requested results of the PPE audit. One audit (with five 'yes' or 'no' questions) had taken place in the last 12 months, in May 2018. It was not clear where the audit had been carried out. This audit had only observed five staff members in one area and we did not consider this to be sufficient assurance of compliance oversight. One staff member of the five had not been compliant, but there was no indication of what action had been taken.
- The provider did not have oversight of staff compliance with equipment decontamination. We requested evidence of the equipment audit, which had been carried out once in the last 12 months, in June 2018. There were six 'yes' or 'no' questions to be answered for example, 'does all equipment appear clean?', 'is the communal bath in a clean state?' and 'is it easy to see if equipment is clean prior to use?' The audit did not identify which area it had inspected. One question was not answered at all, and we did not consider this audit provided sufficient assurance that correct cleaning procedures were consistently being carried out.

Environment and equipment

The maintenance of equipment was not managed safely and placed people at risk.

- Maintenance staff were not qualified to undertake the refurbishments, tests and checks they had been undertaking. Whistleblowers raised concerns before and during the inspection about the competency of maintenance staff working at Glenside. We were told the contract for maintenance had changed when the new owner took over in August 2017 and now maintenance workers were employed directly by Glenside on a permanent basis. Staff were concerned that the maintenance workers were carrying out repairs, such as electrical repairs, when they were not qualified electricians. The maintenance workers did not speak English and staff told us they had difficulty in communicating concerns to them.

- The maintenance staff were also 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 identification 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 was only able to support skilled staff in a construction site and not qualified to manage maintenance of specialist equipment at a hospital. We have referred these issues to a number of other agencies including the fire department.
- The provider did not regularly risk assess the hydrotherapy pool despite a chemical incident, in March 2018, during which the police and the fire department were called. The risk assessment for the hydrotherapy pool was not reviewed annually and was last reviewed in 2016.
- The provider did not evidence that safety checks for the gas heating system had been carried out. We requested these certificates formally, but were provided with the certificates for gas safety checks related to catering equipment and not for the gas heating system.
- People were not always provided with sufficient equipment. During the inspection, ward staff told us there was often a shortage of equipment for moving people safely. However, two senior nurses told us there was enough equipment for patient needs and gave an example of how a broken mobile hoist had been repaired promptly by an external company. Other staff told us there was not enough equipment and recalled situations when four or five patients needed the mobile hoist or standing aid but the equipment was elsewhere on the site and not available.
- We were told by ward staff that seven overhead hoists were broken during the week prior to our inspection. The maintenance workers tried to fix them on several occasions, but were not trained so the hoists were not working for several weeks. As a result, patients spent more time in bed instead of undertaking rehabilitation activities. This was because ward staff did not want to breach manual handling policies by handling the patients incorrectly. However, we did not see these issues reflected in the patient records we reviewed and all equipment was working on the day of the inspection. The reporting process was for staff to escalate this type of concern to the health and safety lead. We did not see any evidence this had been reported formally, escalated or acted upon and issues with equipment were not reflected on the risk register.
- Equipment maintenance was not always occurring when it was due. For example we requested and received the maintenance schedule for ward equipment which showed there were enteral feeding pumps, suction equipment and defibrillators outside of their servicing dates.
- There was no system for auditing or ensuring equipment was available, or fit for use. We reviewed the monthly audit reports for equipment, which was presented as an annual overview. Information had only been captured as a snapshot in the month of June 2018, and it was not clear which clinical area the outcomes were from. The audit looked only at whether equipment was single use, and if not, whether it had been decontaminated after use.
- The hydrotherapy pool had been out of action for six months and patients were not able to access this as a rehabilitation therapy. An incident report dated March 2018 stated this was thought to be due to a chlorine gas leak. An investigation found that one of the maintenance staff had failed to read the instructions before mixing the chemicals properly. The staff member had not received training in this procedure, and was not supervised whilst carrying out the task.
- At the time of our inspection we discovered that a fire escape gate in the garden area outside Nadder ward had been boarded up by the maintenance staff. This was an evacuation route. We understood the reason was because the gate was noisy and this had been the case for some weeks, but staff had not reported the occlusion of the fire escape. Staff corrected this as soon as we informed them of the risk to staff and patients if there should be a fire on the ward. There were no maintenance staff available with the right skills at the time of our visit so an outside contractor was called in immediately and they remedied the situation.
- The provider was not compliant with the requirements under the Mental Health Act (MHA) code of practice, which apply in any hospital where patients might be detained under the MHA. On Ebble ward which was a

mixed sex ward, there was only one patient lounge. The code of practice (paragraphs 8.25-6) states women-only day rooms should be provided. Women-only environments are important because of the increased risk of sexual and physical abuse and risk of trauma for women who have had prior experience of such abuse. Consideration should be given to the particular needs of transgender patients.

Assessing and responding to patient risk

Staff did not always complete and update all relevant risk assessments for each patient, or ensure their physical and rehabilitation needs were fully met. They did not always keep clear records or ask for support when necessary.

- Several staff, ranging from senior leaders to ward staff and therapists told us about their concern that some patients were being accepted to the hospital whose needs could not be met fully in the environment. Whilstleblowers had raised this as an issue before our inspection. We also reviewed over 20 exit interviews from staff who had left the hospital, and found this information repeated there. Several staff told us they used to work to a very clear criteria for admission, but since under new ownership, staff said they had been instructed to accept all patients.
- We spoke to the owner about these concerns and we were told they were incorrect and that patients were all risk assessed carefully prior to admission. We requested information about how many patients had been refused admission based on risk in the last 12 months, and the owner told us he did not keep a record of the number of patients who had been refused admission or the reasons why. We requested evidence to demonstrate a review of the admission criteria but the owner told us this had not been reviewed.
- During this inspection we did not find any evidence of patients who had been inappropriately placed. Alongside our inspection, each patient was having a separate independent review by another regulatory agency to ensure their needs were being met.
- Staff told us that they had 48 hours notice of all admissions, and a junior doctor gave all patients a full physical health check on admission. Nursing staff told us they would take a full range of patient physical observations on admission and these would be repeated as required. Staff told us that patients might have input from different team members to support their physical health. Physiotherapists devised exercise regimes for patients who needed this and dieticians assessed patients who needed specialist input.
- Care plans and risk assessments were not always completed and reviews did not evidence meaningful discussions with patients about their care needs. We reviewed four care records, including risk assessments and care plans in depth. Each care plan was individualised to take account of patients particular care needs, and comprised various sections; for example, mobility, malnutrition, communication and activities. Each section then had a review date. The majority of reviews were recorded as completed, although in each set of the four care plans, we found some gaps. Some of the updates were comprehensive, although many stated 'remains relevant' and this we found to be a theme, and therefore not a meaningful account of dicussions with the patient about their care needs.
- In one care plan, we saw a number of risks had been identified, for example, risk of violence, risk of absconding, lack of awareness of road safety, but none of these risks had been entered into the care plan. In another, we found a patient with challenging behaviour was to be managed using a particular form of restraint. The update for this patient stated the form of restraint was not appropriate as the patient was too strong for staff to manage, but this had not prompted a review of techniques and no further advice had been documented as sought. In addition, the records indicated there had been an increase in violent and aggressive behaviour from this patient, but we could not see any action had been taken, or the matter had been escalated to ensure the safety of the patient and staff.
- Care plans for patients at risk of absconding were not followed. Ward staff told us there had been incidents of patients absconding from the ward. This was confirmed by two of the senior managers we spoke with. We found evidence of one patient who had been found wandering in the road and returned to Glenside and another vulnerable patient who had been able to abscond and purchase alcohol. We reviewed the incident form and found this had occurred despite the care plan stating the patient required constant supervision. This incident had not been reported as a serious incident or investigated fully even though the patient had been

transferred to an acute hospital for treatment as a result. We found no evidence of any actions having been taken to review the care plan, prevent recurrence or manage the ongoing risk.

- One care plan of a patient with diabetes did not include any specific guidance relating to management of the condition, for example, suggested blood sugar ranges. When we asked staff how this was being managed, we were told a diabetic menu was offered, and the patient was discouraged from eating sweets or chocolate. This was not sufficient to guide staff in the safe management of this patient. Another patient who was at risk of malnutrition had refused to be weighed as directed in the care plan; the care plan had not been reviewed to determine alternative ways to ensure this patient's risk of malnutrition was safely managed.
- It was not clear who was responsible for patient activities on the ward, or if they were taking place as set out in care plans. Some of the care plans we reviewed included advice for staff to develop an activity timetable as a way to help manage risk from violence and aggression, and to help prevent boredom. We could not see if this had been done when reviewing the care plan. Patients told us about group activities such as art, breakfast club, walks and cooking. There was an activity centre at the hospital where some activities were held. Patients told us that staff did not really do any activity with them on the ward such as playing cards or board games. There had been two activity coordinators at the hospital, but both coordinators had moved on to other roles in the hospital. Ward staff told us they were not clear as to who should be completing the activity timetables now. The provider planned to recruit one coordinator to replace these two staff.
- Rehabilitation activities were often concentrated into mid-week days due to lack of available staff at the weekend; allied health professionals told us they had raised this many times with senior leaders. We found a lack of strong emphasis on patient activity in care plans and activities were not always available to patients. We saw no evidence that outcomes associated with activities were being monitored or reviewed. In addition, activities were not always documented so we could not be assured they had taken place. A family member who contacted us prior to the inspection told us that lack of activity contributed to problems in their relative's behaviour. Their relative had started smoking at the unit and had been given his first cigarette by a member of staff when he asked for one.
- We asked about how the service monitored patients for the risk of deterioration. Ward and nursing staff said they used a national early warning score (NEWS) which indicated whether there were any concerns about a patient's condition deteriorating. We asked to see evidence of this during the inspection as we could not see these charts in the care records. Staff told us there were no patients requiring a NEWS chart at the time of our inspection and all previous NEWS scores, and other observations were recorded electronically. A NEWS chart would be commenced if staff felt one was required; it was not commenced on admission or used to detect or monitor any changes. We were unable to test this as on the day of the inspection, the computer systems were not working. Staff told us they completed observations regularly but we were not assured there was a system in place to ensure this.
- An allied health professional (AHP) told us that patients' needs were discussed once a fortnight. They felt communication between ward staff and AHPs was not enough to ensure that patients' care was at optimum levels. They also alleged the owner, who did not have a clinical background, would override clinical decisions. For example, decisions about standing patients up, or medication regimes that staff were advised to use by the owner against clinical advice.
- We heard this information repeated from other managers we spoke with and we reviewed exit interviews from some senior staff who had left. We were shown a copy of a letter that had been written to the owner containing information about two incidents; one involving a decision to alter a course of medication for a patient, and one other altering the course of treatment, against clinical advice. We asked the owner about this and he told us this information was incorrect, but offered no further explanation. We asked for evidence of an investigation into both incidents during the inspection, but the owner told us they had not been investigated.
- We were told that risk rounding took place each Friday. This was a discussion assessing patient needs and to ensure the service was safe for the weekend. This round was attended by the resident medical officer (RMO) and

the on-call manager, but did not include AHP's or nursing staff. This outcome of this meeting was not recorded and we could therefore not review any evidence about how effective this was.

- Before patients were discharged from the hospital a multi-agency meeting was held to assess potential risks and patient needs. We observed one of these meetings. This would normally include the funding commissioners via teleconference but they were unable to join on this occasion because the IT systems and telephones in the hospital were not working. Attendance at this meeting included the consultant in charge (chair), senior nurse, family members and therapists – one speech and language therapist, and one physiotherapist plus an administrative member of staff for minute taking. The consultant discussed the patient's current state; what options and further tests were available and guided the family in decision making, answering their questions and explaining the investigations.

Nurse and Medical staffing

The service did not have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- Patients were cared for on the ward by registered nursing staff, and rehabilitation/care assistants and therapists provided support for the rehabilitation of patients.
- We measured staffing levels at the hospital with Specialised Neuro-rehabilitation Service Standards, updated 30th April 2015. This showed Glenside hospital staffing to be below recommended staffing levels as follows: medical staff – consultants accredited in rehabilitation medicine - short by two staff; medical staff – junior (training grades above FY1) - short by two staff; nurses (band 5 or above) depending on acuity – short by 52 staff; the hospital had 49 rehabilitation assistants who were staff below band 5 grade but there were no recommended standards for this level of staffing; physiotherapists, depending of proportion or patients with tracheostomy or requiring 2:1 therapy – short by four staff; occupational therapists – short by eight staff; clinical psychologists, depending on behavioural problems – short by four staff.
- There were not enough substantive nursing or allied healthcare professional staff to support patients with their personalised needs. Gaps in rotas were filled by senior ward staff requesting bank and agency staff. However, the arrangements with the agency providers used, did not keep people safe at all times. We reviewed staffing rotas and found there to be high levels of agency staff usage. One week in September 2018 there were 35 agency filled shifts on one ward out of a total of 68 shifts for that ward (more than 50%). This excluded shifts stated as being reserved for management time.
- There was a high turnover of staff at the service; senior managers told us the figure was 60% for qualified nurses and therapists over the last 12 months. Managers had found difficulties in recruiting to the roles for nursing, therapies and care staff. They had encouraged recruitment by offering accommodation on the hospital site and tried to recruit to permanent posts when agency staff had worked there regularly.
- Some agency nursing and care staff had been working for the service regularly over a period of time and were familiar with the patients, their needs and how to support them. However, there were many gaps in the rota that could not be filled by these staff. Another agency was being used to provide staff to fill the rota gaps for rehabilitation/care assistants. These staff were arriving from countries outside of the United Kingdom and had not had their English language skills assessed. The owner informed us there was not a system for assessing English language skills. He told us they would be sent back to their country of origin if they did not improve their English language skills whilst on probation, and that on average, 30% of these staff were sent back.
- There was a theme across all areas of information we received including: complaints we reviewed, exit interviews from staff, whistleblowers and patients that English language skills of staff was causing problems across the hospital. Patients told us of their difficulties being understood and they could not understand the agency staff from overseas. Relatives of patients told us they often heard staff conversing in their own language between each other which excluded and confused the patients. Staff commented that patient care plans were not able to be completed by staff with limited English, or were often illegible and it was difficult to get these staff to carry out their duties to the required standard.

- Permanent staff found the task of supporting the high volume of new agency staff through their induction overwhelming, and the induction process was hindered by the communication difficulties.
- The service recognised there were some therapist vacancies which, when filled would still not provide enough physiotherapy and occupational therapy staff to meet the recommendations. There had been a large number of therapy staff leaving the service over the previous 12 months and vacancies still existed. Therapists had been instructed to reduce therapy times to 30 minutes for each patient instead of according to the individual patient's clinical need.
- Handovers at change of shift were poorly managed. One of the concerns identified was that new staff did not know the needs of the patients well enough to handover care delivered and needed. This had been reported to senior managers who had incorporated the comments into the quality improvement plan for the unit. Actions were for a structured handover to take place but we saw no update or review of the actions, or any evidence to suggest structured handovers were taking place.

Medical Staffing

- Two consultants had oversight of patient care and treatment within the hospital. They attended discharge meetings when required and reviewed patient care during the week although we do not know how frequently this was as there was no formalised programme in place.
- Day to day medical staffing was provided by an agency. A Resident Medical Officer (RMO) was on duty 24 hours each day for seven days per week on a sessional basis. The agency supplying RMOs had changed during the previous 12 months. The RMOs supplied were not always familiar with the service. Information we received expressed concern about competencies of the new agency RMOs and nursing staff expressed how they spent more time explaining patient needs to the doctors. One incident reported was due to an error in medical judgement and resulted in hospitalisation of the patient.

Records

Staff did not always keep accurate records of patients' care and treatment. Records were not all up to date or truly reflective of the patients' needs.

- We reviewed a sample of six care records, an additional six records of detained patients and we looked at four full care records in detail. All records reviewed were mostly complete and up to date and all had care plans, but these were of variable quality. Some care plans had been comprehensively written and had appropriate updates. However, in all of the four records we looked at in depth, we found gaps in reviews and in two, unsigned and undated entries. In two sets we found that identified risks had not been transferred into the care plans and this is discussed further under the assessing and responding to patient risk section above.
- We found in three of the four sets of records that care had been described as being in the patient's best interests, but we found no evidence of any capacity assessments having been completed. This is considered further under the Consent, Mental Capacity Act and Deprivation of Liberty Safeguards section below.
- Some updates following reviews were thorough and had been completed in conjunction with the patient and fully documented. Others stated 'remains relevant' but it was not clear that a thorough review had taken place. We found this statement at times, in all care records we reviewed. In general, we found the psychology updates to be of a high quality.
- It was difficult to track through the frequency of therapy sessions as there were multiple sheets where sessions were recorded, with overlapping dates. This made it hard to see at a glance if the appropriate sessions had taken place, or were due.
- The provider was not monitoring the quality of documentation. We requested evidence of documentation audits which we were told were carried out monthly. The last documentation audit had been carried out in November 2017 and only looked for evidence that entries were signed and dated. We were not provided with any up to date or meaningful documentation audits.
- The provider was monitoring the quality of care plans but steps were not being taken to improve poor compliance. We reviewed care plan audits for Bourne and Avon wards. Data had been collected between

October 2017 and October 2018, looking at patient care plans to ensure they had been written, reviewed and updated at least once per month. The data covered 12 areas, including communication, personal care, safe environment, behaviour, emotional health and wellbeing. There was a section for data collection entitled 'religious and cultural needs' but entries were marked as either 0% completed or not applicable.

- The results across the year, and the parameters were variable, demonstrating some months where documentation was very poor for example 0-20% completion, and some parameters where documentation was consistently not meeting target, for example, entries for mobility ranged between 56 – 86%. There was no evidence of any actions being recorded or taken to improve those areas demonstrating poor compliance.

Medicines

The management of medicines at the hospital was not safe and there were problems with the supply of medicines into the service. There was no clinical pharmacy oversight or service to support medicines management which increased the risk of errors.

- The supply and administration of medicines was not safely managed. Medicines were supplied by an external pharmacy under a Service Level Agreement (SLA). We were made aware by whistleblowers ahead of the inspection and by staff during the inspection that there were a number of issues with the supply and management of medicines, for example, medication would be sent in the wrong box, or for a patient not at the hospital. The owner told us he had changed the pharmacy supplier in December 2017 after he took over the service, and although there had been concerns and issues raised initially, he understood these had been resolved. We found there were still concerns and issues with the supply of medicines, and we saw concerns were being raised at the manager's meetings, but these had not been escalated or acted upon.
- The process used at Glenside to obtain medicines was not suitable for a hospital environment. We reviewed SLA with the new supplier; the title of the SLA read 'Glenside Salisbury – all existing care homes and new ones under same management'. This had been signed on 14 December 2017. This was a nine-page contract which set out services were to be provided to care homes. There was no provision in the contract for any hospital functions, clinical intervention or screening of prescribing. We contacted the pharmacy supplier who confirmed they had been contracted to provide services similar to the service provided to care homes, and not a hospital.
- In care homes patients' medication regimes will usually be stable and issued long term, however, in acute hospital settings, frequent changes of medicines, doses or routes would be more common, for example we found 11 changes required on the day of the inspection. The contract set out an advisory service, which meant staff could phone the pharmacy if they had any questions, but no visits to the hospital to support the doctors or nursing staff by a pharmacist were included.
- The new arrangements meant that stock at the hospital was minimal as would be usual in a care home setting; therefore, any changes in medicines required, dose or route would have to be specifically ordered. This had the potential to cause delay for hospital patients receiving their medication as prescribed since there was no pharmacy provision on site. If ordered before 11am, medicines could be delivered the same day, but if ordered after 11am, it would not arrive until the following day.
- There was no clinical pharmacist service provided to the hospital and no clinical pharmacy input or oversight. Under previous arrangements, a pharmacist would attend the wards and review prescriptions and conduct medication audits. The pharmacist would meet weekly with the medical staff, and attend the governance meetings. There had not been a pharmacist on site to provide these functions since the new contract had been implemented. Nursing staff on the wards told us they missed this service and felt vulnerable. They also told us they had to check and double check everything just in case, which was time consuming. We observed nurses administering medicines, and found they were careful and thorough.
- The way medicines were ordered and supplied was labour intensive and had the potential for human error. Under the new arrangements, medicine was supplied and administered from a Medication Administration Record (MAR), and not from a signed prescription record as would be expected in a hospital. The MARs we found in use were designed for use in adult social care settings where changes were not so frequently required, and not

for use in hospitals. Each MAR had a box for staff to sign when medication had been administered, but did not allow for any amendments to medication, doses, frequency or route of administration. If changes were needed, a new MAR would need to be generated.

- The process was that the RMO would write up a list of medications required for each patient. These would then be transcribed by the nurses onto another form and faxed to the pharmacy. The pharmacy received a faxed signed order as a prescription from which they generated the MARs, but pharmacy did not always collect or access the original, because we found the originals still stored in patient files. This meant any errors in transcribing could be missed. The nursing staff then administered medication from the MAR instead of a dedicated patient prescription, which meant there was a lack of oversight, checking and flexibility that you would expect to find in a hospital environment.
- Any transcription errors in the orders would be replicated on these MAR. We saw one patients' MAR where the prescribed dose of medicine on the MAR differed from the dose transcribed onto the order form. It was not clear which dose the patient should have been receiving and we could not be assured that this patient was receiving their medicines as the prescriber intended. NMC standards for medicine management (2007) stated 'Transcribing should only be undertaken in exceptional circumstances and not routinely. Any medication that you have transcribed must be signed off by a registered prescriber'.
- We saw evidence of 11 errors that nursing staff had picked up and were processing on the day of inspection; these patients' medicines had to be re-dispensed and their MAR re-printed which led to a delay. We saw emails between the service and the pharmacy detailing these issues, and we found these errors had not been entered onto the service's electronic reporting system. For example, patients requiring medicines suitable for administering directly into the stomach via a Percutaneous Endoscopic Gastrostomy (PEG) where instructions had changed; medicines which had been prescribed in an increased dose; and medicines changed from 'when required' doses to regular administration. The nurses had to initiate the process of reordering the medicines as described above, and in some cases we found there were delays of over two days in patients getting the prescribed medicines.
- Nursing staff told us MARs were not always up to date and would often contain incorrect dosage, route and frequency and they mitigated the risk by double checking them frequently. All clinical ward staff we spoke to were aware of the potential risk to the patients and had raised this to their managers on several occasions. We saw one patient's MAR which was in two different forms. One part was hand written and the other was printed. There was duplication in the medicines listed on both types and some medicines listed which had been discontinued. Nurses had amended the MAR, however there was no original prescription to check this against when administering the medicines to ensure the correct medicines and doses were given, and neither type of chart was signed by the prescriber.
- Medicine audits were conducted monthly and we reviewed the results which were presented as an annual overview. The audit showed gaps in data collection across a number of months on each ward. The results were variable, with some months seeing a sharp decline in medicine management. For example, on Avon ward not all entries on the MAR form had been signed by two staff members as required by the service's policy: April 2018 (0%), May 2018 (57%), June 2018 (0%) and August 2018 (25%). On Bourne ward, entries between June and September 2018 results showed 0% had been signed by two staff. Where patients were prescribed medicines with variable doses, these were required to be prescribed separately. On Bourne ward between August and October 2018, 0% had been signed separately, and on Avon in June 2018, only 50% had.
- Other examples included in October 2018, only 10% of prescriptions recorded the route of administration on Bourne, and on Avon the results were variable: August 2018 (83%), September 2018 (38%) and October 2018 (50%). We found not all medicines administered had been signed for on the MAR charts. On Bourne in August 2018 (0%), September 2018 (0%) and October 2018 (56%). On Avon in April 2018 (56%), May 2018 (29%), June 2018 (57%), July 2018 (38%), August 2018 (100%), September (75%). On four occasions in the last 12 months the fridge temperatures were recorded as being outside of acceptable ranges, but the entries against these stated no action was taken. We requested but were not provided with any evidence to show what actions were being taken or how the service was addressing or seeking to improve the issues arising from the audit.

- We saw details of 14 errors between May 5th, 2018 and July 9th, 2018, although staff told us about other incidents which had not been reported, and we saw email evidence of incidents reported to the pharmacy but not logged on the hospital reporting system. Staff told us they had stopped reporting many medication errors as no action was taken. This was confirmed to us by other senior governance staff, who also confirmed they were aware of ongoing issues and complaints from staff about pharmacy, but these concerns had not been escalated as a risk and were not on the risk register. These concerns had been raised at senior management meetings but had not been formally actioned (see under governance).
- Medicines were stored securely in locked cupboards that were accessible only by the key holder or nurse in charge.

Incidents

The service did not manage patient safety incidents well. Staff recognised incidents but did not always report them appropriately. Not all incidents were reported or investigated and lessons learned were not shared with the whole team or the wider service.

- The processes in place for managing incidents was not effective. Whistleblowers told us before and during inspection the electronic incident reporting system was not being monitored because staff were not assigned to review online reporting of accidents and incidents. Senior leaders told us these were automatically sent to the senior nursing staff, the registered manager and the health and safety lead (H&S) for the service. We were unable to fully test this during the inspection because the IT systems were not functioning.
- The senior manager responsible for incidents was leaving their post and the health and safety lead had left. The clinical lead was not clear about who would be taking over this role and was not able to assure us that incidents were being reviewed in a timely way.
- There was a backlog of incidents awaiting review and investigation. Staff on one ward expressed concerns that there were several outstanding incidents that had not been reviewed by the manager. We were not able to review the numbers outstanding as the IT system was not working, however senior managers confirmed to us there was a backlog, although they could not tell us how many were outstanding. Senior staff also shared with us concerns over the number of incidents that had not been reviewed in months, meaning there were potentially unmanaged risks for those incidents raised.
- Ward staff told us there was a culture of staff not wanting to raise incidents as they knew it was adding to the long list of incidents in the system, and that they did not have any feedback or learning around their incidents. We were told by senior managers that the culture of incident reporting had changed in the last year, and staff were now discouraged from reporting as they felt blamed.
- An example we heard about was the reporting of falls. Staff had been reprimanded at a staff meeting for reporting so many falls, and comparisons had been made with the sister hospital where they were told falls did not happen. One senior manager told us the incidence of falls reports had sharply declined over the last 12 months due to this. Reports of falls were monitored by senior managers. Figures reported for the whole organisation of Glenside Salsbury showed that between August 2017 and August 2018, reporting of patient falls had reduced from 17 per 1,000 bed days to seven per 1,000 bed days. Reports of patient falls with harm had remained fairly similar of 1 per 1,000 bed days.
- Investigations into incidents were not taking place and actions were insufficient to prevent recurrence. Prior to and during the inspection, the provider told us there had not been any serious incidents in the last 12 months. We asked to review all incident reports raised during the last 12 months and these were provided. Some actions were recorded on the sample of ten we looked at, but these were not sufficient to address the issues raised. We were unable to review the associated investigation reports on site because of the issues with IT and we were told these were stored electronically.
- Following our inspection, we asked the service to send examples of investigation reports in response to incidents during 2018. They provided 12 months of the quality and safety board minutes, but no investigation reports. For example, no investigations had been carried out into patients absconding from the wards (seven in August 2018), or incidents where staff had been injured. The minutes showed there were two recorded serious

incidents in June 2018 which had met the duty of candour threshold but we were not provided with any investigations into those or any evidence that duty of candour had been applied.

- We reviewed an incident report dated 9 October 2018. The incident report described that three staff had been involved in an incident and two staff had used medium to high level restraint (MAPA) holds. An injury to a staff member had resulted requiring hospitalisation. We saw documented that two staff involved did not have the relevant training to ensure they did this safely. The incident form did not contain any actions to ensure correct training was provided for all staff who may be called to an emergency situation. An investigation was not undertaken. The form stated 'no review required' under the sections headed 'physical intervention care plan review', 'behavioural risk assessment review' and 'root cause analysis'. There was no evidence of any learning from this incident or controls put in place to prevent recurrence. The seriousness of the incident was not recognised.
- We were told by senior leaders that some incidents were reported as accidents, for example injuries to staff, and a separate database was held by the health and safety manager for those. At the time of our inspection, that post was vacant and we could not identify who was managing the database. No evidence was provided to demonstrate investigation had taken place into those incidents reported as accidents.
- When we asked the owner, and the operations manager what the key themes and trends were from incidents over the last 12 months, they were unable to tell us. There was no process to align incidents with the accidents database, the risk register, or complaints. The provider was not able to give us any examples where learning had been shared, or where improvements in care had been made as a result of incidents, or investigations. From the documents we reviewed, we could not see any evidence of learning, or sharing of lessons across the hospital or wider.

Safety Thermometer (or equivalent)

The service did not monitor safety effectively or use results well. Staff did not routinely collect safety information across all wards, or share it with staff, patients and visitors. We found no evidence to show managers used this to improve the service.

- We were not assured the service collected all relevant safety information required, for example, observations or NEWS, and what was collected was not used to identify trends or issues, or to improve the service.
- The service had a data collection tool for the clinical areas, which included monthly audit against a number of safety and risk parameters. These included: weight, malnutrition assessments, manual handling risk assessments, falls risk assessments and oral hygiene assessments. We reviewed the results of the monthly audits which were presented as an annual report. On Avon ward: in April, May and July 2018, none of the targets (set at 90%) had been met for any of the above parameters and on Bourne ward, targets were not met in January, February May or September 2018. We asked for but did not receive evidence of actions taken to improve deteriorating or poor audit results, or any learning or additional training being provided.

Are long term conditions effective?
(for example, treatment is effective)

Competent staff

The service did not have systems and processes to make sure staff were competent for their roles. Some training in specific skills for roles was provided but managers did not ensure these were attended by all staff.

- Some staff did not have their skills assessed before they cared for patients. There was no system for assessing English language skills of new agency staff. We heard of several occasions when this had caused a problem with how patients were cared for. Some incidents had been reported to managers and others were not. Without a basic understanding of English, staff were unable to accurately interpret patients' individual care plans. Ward staff told us this had led to some patients with behavioural issues and reduced coping skills, wandering

from the ward areas and being able to walk into the road, because staff caring from them did not understand the instructions for supervision in the care plans.

- There was no formal training available for staff to supervise patients when they were using the hydrotherapy pool. The owner told us he had organised training to be delivered to staff but staff had not attended the sessions. The pool was not in use during our visit.
- The service provided additional training for registered nurses to complete. This was to provide them with specific skills and knowledge needed to care for their patients. However, the trust could not supply details about how many qualified nurses had specific rehabilitation training; the national recommendations as set out above were that at least 40-45% of nurses should have this training.
- There was a risk that newly admitted patients would be cared for by staff who were not trained to care for their specific needs. Modules for additional role specific training included: goal planning, prescription & administration (e-Learning), tracheostomy care, care of the patient on a ventilator and administration of oxygen. There was no formal programme for this training and we were told it was delivered on an ad-hoc basis, or when the need arose. There was a risk that training would not be delivered until after a new patient's arrival. We saw an example where two staff administering medication to a detained patient did not have the relevant training and did not understand the legal processes for ensuring or checking that medication was administered lawfully.
- Concerns were raised with us about MAPA (management of actual or potential aggression) training. We reviewed an incident report dated 9 October 2018 also referred to above under incidents; we saw documented that two staff did not have the relevant training to ensure they did this safely. A registered nurse told us there had been occasions where staff had used inappropriate MAPA holds. The registered nurse said this was because the staff were not trained and "were frightened" when people became challenging. The use of restraint by staff who have not been trained increased the risk of injury to both the individual and staff. There was no evidence that staff had considered less restrictive support prior to the use of the MAPA hold. We could not confirm if the use of the hold was in persons best interest. CQC adult social care colleagues raised a safeguarding alert for this person.
- There was a training department at the hospital and managers told us they monitored attendance at training courses. Figures for 30 November 2018 showed registered nursing staff compliance in completing role specific training varied between 21% and 83%. Staff training in these subjects did not meet the 90% target for compliance. The lowest training compliance (21%) was for training around oxygen administration. However, it was not clear how the provider determined which staff should attend which training and managers we spoke with were unable to explain the systems and processes in place.
- There was no oversight of training or competencies for medical staff. Following our request for training compliance information, the service did not provide any training data for the medical staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards.

Not all staff understood their roles and responsibilities under the Mental Capacity Act 2005 or DoLS. Patients described as lacking capacity to consent to admission and treatment did not have an assessment of their capacity recorded. Legal processes for detained patients were not adhered to.

- 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. This was not well understood by staff and best practice was not reflected in the care plans we saw.
- The recording of capacity to consent to treatment was not consistent. We found that patients described as lacking capacity to consent to admission and treatment did not have an assessment of their capacity recorded. We could not find where staff recorded information about detention; for example, we found in three of the four care records we reviewed in depth, statements from

staff to suggest decisions had been made about patients care based on their best interests. There were no capacity assessments documented to support those decisions. One patient had no recording of their capacity to consent to treatment, despite staff recording on a second opinion appointed doctor (SOAD) request form, that the patient lacked capacity.

- Staff told us that patients who lack capacity were automatically referred to the Independent Mental Health Advocacy (IMHA) service but this was not supported by the care record of one patient, who was recorded as not having capacity to understand their rights but having declined referral to the IMHA service. This patient's family expressed concern that there was a delay in referral to IMHA of several months and they had needed to make the referral themselves.
- People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. This is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
- The provider did not have robust procedures in place to support automatic referrals to the tribunal service for those that did not apply. One patient should have been referred for a Mental Health Review tribunal (MHRT) after he had been detained for 6 months in July 2018, this did not happen and was not picked up by MHA administrator or the responsible clinician (RC). MHA code of practice at 37.39 says: "Hospital managers are under a duty to refer a patient's case to the Tribunal in the circumstances set out in section 68 of the Act. Hospital managers must refer patients when six months have passed since they were first detained…" . Tribunals are a statutory safeguard and can discharge patients.
- Hospital managers review hearings had not taken place. Three patients had had their detention renewed in July 2018 but had not been referred for hospital managers' review hearings when this happened. The hospital managers must do this (paragraph 38.12 MHA code of practice) as it is a safeguard for the patient, the panel can discharge the patient from hospital.
- The necessary consent for treatment was not always in place. There were six patients who were detained under the Mental Health Act 1983 at the hospital. They had been detained and were receiving medical treatment for longer than three months. Two of those patients were receiving psychiatric medication without the necessary (T2) certificate of consent to treatment, or the (T3) certificate of SOAD authorisation, or section 62 urgent authorisation of medication form in place to authorise their treatment. This was raised with the provider as an urgent issue to address.
- The provider had failed to provide notification to CQC regarding detained patients. Two patients had (T3) certificates of SOAD authorisation that dated back to 2016. The hospital should have submitted a report updating CQC on the patients' condition and confirming that the treatment was still required when the patients' detention had been renewed a few months prior to our inspection but this had not been done.
- The provider told us there had been a contract in place with a local mental health hospital to manage all the administrative functions for detained patients but this contract was no longer in force. During our inspection, we were unable to identify any senior member of staff with sufficient knowledge or training to undertake this role. Senior leaders we spoke with did not understand what the issues were, and we had to explain why these detentions had not followed the formal processes to ensure the patients' rights were protected.
- There was a consultant in rehabilitation medicine who acted as the responsible clinician (RC) for the detained patients, but they had not received additional training for this role. An administrator had also been appointed, but they had not received additional training for the role either. Ward doctor input was provided by registered medical officers (RMO) who worked sessional shifts at the hospital. However, ward staff advised us during the inspection that there used to be regular RMO doctors who were familiar with the service, but this had changed since the RMO contract had also changed, and they frequently had to explain to the doctors things they need to know.

Seven Day Working

The service was working towards implementing a seven day service.

- We were told by the owner that there was a project plan in place to introduce seven day working led by the two health and safety (H&S) leads across the organisation. He told us there were groups working together to achieve an overall strategy. We asked for, but did not receive the strategy to support these plans.
- The physiotherapy team at the Raphael sister hospital was working seven days per week and integrating with

the wider therapy teams. For example, the owner had brought some of the base team to Glenside to provide training for this project but there had been significant resistance to this, and the training and integration was unsuccessful.

- We were told by the owner that a new lead, who was to commence in post in December, would focus on, and work towards a seven-day week service. "The Raphael physios will interchange with the Glenside team". However, the roles allocated to lead the project were vacant posts. This was because a few days prior to our visit, the H&S manager had left their post and since our visit in early November, the newly appointed H&S lead at Glenside had resigned after just a few weeks in post. The vacancies data above shows that the organisation had been unable to recruit a physiotherapy lead.

Are long term conditions well-led?

Leadership

Leaders of the service did not have the right skills and abilities to run a service providing high-quality sustainable care.

- The senior leadership team had changed in the last 12 months, and at the time of our inspection was unstable. The organisation had come under new ownership in August 2017. Since that time there had been several changes of leaders, for example, there had been four human resource managers in 12 months, two health and safety managers and at the time of the inspection this post was vacant, and there was an interim operations officer who had been in post for eight weeks, based at the sister hospital.
- There was no programme of development for senior leaders and we found evidence of senior staff being assigned to roles for which they had not been trained. For example, freedom to speak up guardian and legal administrator for detained patients. Three of the senior staff we spoke with had resigned and were working their notice periods. They told us the new leadership style and structure was not suited to them. They raised concerns with us about being asked to undertake roles for which they had not been trained, and did not feel there were training or development opportunities available to them. They also told us roles and responsibilities had become blurred and there was uncertainty around what was expected of them. We asked the owner about development for senior leaders and managers, but we were not provided with any evidence of development plans or programmes.
- The owner did not have a clinical background although he had been involved in the field of neuro rehabilitation for 35 years and ran other similar organisations in the South of England. We requested evidence of his training and qualifications but these were not provided. The clinical lead was a registered nurse with a background in cardiology who had been working at Glenside for four years and had been the Care Quality Commission registered manager for the hospital since February 2018.
- We could not be assured Fit and Proper Person checks were in place. During the inspection we requested the contracts and job descriptions for the senior leaders but these were not supplied. We were not able to access any personnel files for either of the two directors of the company, or the operations manager as these were not held on site. After the inspection we requested this information again, but it was not supplied. Therefore, we could not be assured that the senior leaders, their experience, skills, and knowledge were appropriate.

Vision and strategy

The service did not have a vision for what it wanted to achieve or workable plans to turn it into action. Staff, patients, and local community groups had not been involved in developing a shared vision for the service.

- The service did not have a documented strategy or vision; the owner told us this was being worked on. We requested evidence of meeting minutes, consultation or draft documents, but the owner told us plans were not yet on paper. We were directed to a document that had been produced by the previous owner, but was no longer relevant.
- Senior staff when asked about the strategy and vision were not able to tell us; one senior leader told us it was "to recruit from overseas" and the owner told us it

was “to implement seven day working”. Another senior member of staff told us it was “to fill the beds”. We were not assured the senior leaders had an aligned or focused direction for the service.

- The provider did not have a clinical or quality strategy. We requested but did not receive evidence of a clinical or quality strategy. The owner told us he was working to bring Glenside in line with its sister hospital the Raphael, but at the time of our inspection, there was no evidence to support this. No gap analysis or similar had been undertaken to identify where the two sites were not harmonised. Senior staff at Glenside were not able to tell us what the vision or strategy was for the Raphael hospital, or what they were being expected to work towards.
- Staff on the wards were not able to tell us about the vision or strategy, although some told us they were still working to the previous strategy, which had been reviewed and developed with staff two years ago, but had not been implemented or taken forward following the change in leadership.

Culture

Managers across the service did not all promote a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

- The staff did not feel valued and their rights and wellbeing were not protected. The CQC had received a significant number of whistleblowing concerns about the leadership of the organisation. During the inspection, we continued to hear from staff about a bullying culture, and a fear of raising concerns. Many staff told us the culture had “become intolerable” and they felt “professionally compromised”. We also found evidence of this in the exit interview information we reviewed.
- Staff did not feel able to speak up when things went wrong. There had been no freedom to speak up concerns raised in the previous 12 months, although we were made aware of in excess of 40 staff who had left and were pursuing employment tribunals against the provider. Staff and managers told us they were fearful to speak up. The freedom to speak up guardian had resigned at the time of our inspection, and has subsequently left the service. They told us there had been no training provided for this role, and no time allocated to carry out the duties.
- Staff, managers and senior leaders told us morale was poor across the hospital and they were in fear of losing their jobs if they challenged the owner. We have been made aware that a number of staff did not feel that their employment rights had been protected. We found a 60% turnover of staff during the last 12 months, which was much higher than expected for a service such as this in a rural setting.
- 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. Some staff we spoke with were tearful and distressed during our interviews with them. We heard from many staff, and found documented in over 20 exit interview forms, that culture had deteriorated in the last 12 months, and this was the most common reason cited for leaving. On at least six exit forms, staff had written they did not want to leave and had loved working at Glenside, but no longer felt they could stay, due to conditions and the leadership style.
- We raised this with the owner during the inspection. He told us staff were reacting to changes and did not like the plans for seven day working. We asked him what action had been taken following the poor staff survey results, and the large amount of information on the exit interview forms, and he told us he was not aware of this information.

Governance

The service did not systematically improve service quality or safeguard high standards of care by creating an environment for excellent clinical care to flourish.

- There was no formal board or governance structure in place. We requested information about the board and how it functioned. Senior leaders we spoke with told us there was not a formal board structure in place. The owner told us there was a leadership business meeting equivalent to a board meeting, which comprised himself, his wife (who is a company director) and an external finance director.

- These meetings had not been formalised into a comprehensive governance structure, and the owner was planning to review the function of these meetings, which we were informed took place quarterly. We asked to see minutes of these meetings for the previous 12 months, terms of reference and standing agenda items. However, only one set containing brief minutes from August 2018 was provided after our inspection.
- No senior management or clinical staff at Glenside had attended the leadership business meeting. No reports, dashboards, quality indicators or papers were submitted for consideration or discussion. There was no annual report for the provider. The August 2018 leadership meeting considered recruitment and noted a small reduction in the use of agency staff and a slight improvement in staff retention. There were no figures to support this. This section noted that staff with English as a second language would be offered language coaching, but the extent of the issue was not documented and it was not clear when these coaching sessions would commence. No discussion was documented around clinical or quality matters.
- The minutes noted occupancy levels were below budget and greater marketing effort was required, and the business continuity plan needed to be reviewed. Reference was made to the creation of a corporate-wide governance board, which would comprise three external members, two doctors and the operations manager. No timescales were included as to when this board would be created, and no information as to terms of reference, reporting lines or standing agenda items. It was unclear how the senior management at Glenside would function together to gain oversight of risk and performance, or to review and develop the corporate functions.
- We saw conflicting organisational charts which related to the structure under previous ownership. During the inspection, the owner told us up to date charts detailing lines of reporting and accountability were available, but we could not access them at the time because the IT system was not working. We subsequently requested these, but have not been provided with them.
- Following the inspection we were sent an undated one page word document entitled 'governance structure'. The sub-heading said 'corporate governance', and indicated there were three monthly meetings, which were to be attended by 'all board members, medical leads and external members'. A further sub-heading read 'reviews and receives reports of: quality governance, safeguarding and incident reports and all other committees'. However, we were not provided with any evidence that this meeting had been functioning, or if planned, when it was due to commence. The document stated an 'annual board meeting' was to be held. Therefore we were not assured there was a functioning or appropriate governance structure in place. Senior staff we spoke with were not able to tell us about reporting lines, or scheduled governance meetings.
- We requested the terms of reference for the corporate governance meetings and we were sent terms of reference, dated January 2014, which set out the governance arrangements at the sister hospital, the Raphael. These did not relate to Glenside Hospital, and had passed the review date of January 2016.
- A two weekly senior managers meeting was held, and we reviewed minutes of those meetings. We found this meeting did not have a clear format or structure, or standing agenda items and was mainly operational in nature. Reports did not appear to be presented at this meeting, for example quality indicators/dashboards, incidents or complaints; if they were, no information was recorded in the minutes to reflect discussions or outcomes. There were no action logs associated with these minutes. Each meeting had a section at the start to discuss actions arising from the previous meetings, but we found actions were not consistently carried forward or closed to reflect they had been completed.

Managing risks, issues and performance

The service did not have good systems to identify risks, plan to eliminate or reduce them, or cope with both the expected and unexpected.

- There were no systems or processes in place to identify or manage current risks. We requested and reviewed the corporate risk register. There were 18 corporate risks identified, but of these, 12 had been entered in 2012, three in 2013, one in 2016 and one in

2017. All of these predated the current ownership. The final entry related to reputation risk, which was a duplication related to the risk of CQC regulatory action, but had not been dated.

- The risk register was not reviewed in a timely way and was not updated. There was a column to indicate timescale for action; for five risks, 'not applicable' was entered, the remainder apart from two stated 'ongoing'. There was no review date set, and it was not clear when risks were reviewed, how they were reviewed, or if they had been reviewed in most cases, since they were entered.
- The actions, controls and mitigations for the entered risks were not sufficient. The grading of risk was as follows: green (1-9), amber (10-18) and red (19-27). There were seven amber risks:potential for major competitor to set up in regional area (12), potential for major fraud resulting in unsustainable financial loss (12), NHS structural reforms (18), recruitment and retention of skilled nurses and assistants (12), potential data breach (12), funding not keeping pace with costs (12) and reputation risk (15). We found there to bea lack of action, control or mitigation documented against these risks.
- Known risks were not captured on the risk register. We were made aware during the inspection of a number of key risks that were not on the risk register, for example, we found there had been concerns consistently reported by staff over the supply of medications which increased the risk of errors. All senior managers we spoke with told us about these concerns, but since using the new suppliers, no evaluation had been undertaken to ensure contractual obligations were being met despite there being an increase in reported issues. We asked the owner about this and he told us he believed the concerns had been addressed, but was not able to tell us how, or direct us to any assurance around this.
- No risks had been entered in relation to the new ownership and the potential impact of changes to policy, procedure and management, for example the changes arising from using new pharmacy and IT suppliers, new staffing agencies and the new contract for registered medical officers. The decision to bring maintenance and administration for detained patients had not been risk assessed, monitored or evaluated.
- There were frequent IT and telephone outages that disrupted service and access to key systems since the IT and telecommunication suppliers had changed, and we observed a complete shut down of all IT and telephone systems during our inspection, which lasted several hours. A protocol had been written for staff to follow when the IT or telephone systems were not working, but this was not recorded or addressed as a risk.
- There was not a clear process for identifying, recording, escalating or reviewing risks. Clinical areas did not keep local risk registers. In the five sets of senior managers meeting minutes we reviewed, we found a number of risks were raised but were not formally logged for action. For example, minutes from July 2018 raised concerns and risks related to pharmacy. The action was to ask the owner to consider going back to the previous supplier, but the errors and complaints raised were not addressed directly. In the same minutes we saw concerns raised by the training coordinator about non-English speaking staff understanding the training being provided. This was not escalated as a risk and no actions were logged to address the risk.
- We requested information from the provider about how they collected, analysed and managed risks, incidents and complaints. We received and reviewed quality and safety board reports for the months between January and September 2018. We were not provided with any information about where these reports were presented, or discussed, or how actions/ trends were being monitored. The reports covered 23 key quality indicators, for example, infection rates and safeguarding alerts. Only 12 of these had targets or a baseline set. Some indicators in the reports we reviewed were showing a deterioration and were rated as red, but no actions were logged against these and we were unable to track any documented discussion arising from the areas of concern.
- The quality and safety board report set out incidents that had occurred, but not the actions taken. For example, in September 2018, three medication incidents were detailed, but no actions logged. Each report had a section for safeguarding, which detailed the incident. In September 2018, the minutes showed there were 18 open cases, with seven dating back to

February, March and May 2018 which had not been closed. Actions were logged against these, but were not sufficient. For example, one safeguarding incident in June 2018 involved an assault of one staff member to another, and the action was to move the member of staff to another ward. Nine of the 18 cases involved peer on peer assault but this had not been escalated as a risk, and we were unable to find any evidence of this being reported or addressed as a trend.

- The provider did not have oversight of equipment and environmental issues and did not take steps to ensure all maintenance was carried out safely. Maintenance staff did not have the competencies and skills to ensure equipment and premises were safe to use. Following a chlorine gas incident when topping up chemicals in the hydrotherapy pool, the provider failed to ensure all relevant staff attended the refresher training, and a risk assessment had not been undertaken since 2016. We saw concerns raised at senior management meetings about new maintenance staff not having current or appropriate skills. We saw no actions had been put in place to rectify this.

Learning, continuous improvement and innovation

The service did not demonstrate a commitment to improving services by learning from when things went well or wrong, promoting training, research or innovation.

- There was a lack of continuous improvement at the service. Staff and managers told us incidents were not being reviewed in a timely way and learning was not shared, which meant similar incidents were repeated, for example the issues cited above around medicines. Issues raised were not discussed fully at a suitably senior level to ensure improvement was appropriately driven.
- The provider could not provide examples of where changes had been made in practice as a result of learning. The overwhelmingly negative culture hindered staff from speaking up or making changes out of fear of retribution. This did not make for a culture where staff could learn from mistakes.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that:

- There are robust systems and processes in place to identify, monitor and evaluate mandatory training and to follow up areas of low compliance, and concerns around non-English speaking staff requiring training.
- Training compliance data to be captured for all staff, including medical and agency staff and oversight of the data and reporting lines need to be clearly stated and implemented.
- All staff involved with patients have completed the MAPA training.
- There are robust systems and processes in place to identify, report and monitor safeguarding concerns. Training for all staff must be in line with national guidance (to include safeguarding children) and roles and responsibilities, including reporting and oversight must be clear.
- There are robust systems and processes in place to consistently identify and control the risk of infection, and that infection control is adequately monitored and reported, with clear lines of responsibility. Also that all areas are cleaned effectively to reduce the risk of cross infection and monitored as cleaned including patient rooms. All staff to follow infection control procedures and use personal protective equipment appropriately, changing it between tasks and between patients.
- The equipment and the environment is maintained in a way that ensures their use by patients and staff is safe and the current arrangements for managing equipment maintenance in house are effective and safe, and repairs are undertaken by staff with appropriate qualifications. A schedule for maintenance is kept and monitored.
- All admissions to the hospital are appropriate and patients are properly risk assessed prior to any admission. Risks to patients are identified, assessed and monitored consistently, and that assessments and care plans are updated and contain enough detail to enable staff to reduce those risks effectively.
- Patients physical and rehabilitation needs must be fully assessed and actions taken to meet those needs.
- Enough staff with the right skills, competence and experience are available to care for patients safely
- All staff achieve a basic level of English language so that they can communicate with the patients.
- Staff keep accurate records of patients' care and treatment, and that compliance is monitored and reported. We were not assured that records were always up to date or truly reflected the patients' needs.
- Medicines are supplied and provided correctly, managed safely and with systems and processes in place to monitor, report and reduce errors.
- Patient safety incidents are managed appropriately. Incidents reporting is encouraged, incidents and trends are monitored, investigated, reported on and lessons learned are shared with the whole team and the wider service.
- Collect and monitor safety data and use results to identify areas of risk and make improvements to the service.
- Staff are trained appropriately to carry out their tasks when caring for patients. This includes staff being trained appropriately to supervise and maintain patient safety when patients are using any equipment and the hydrotherapy pool.
- Patients detained under the Mental Health Act 2015, receive a regular clinical review and systems and processes are in place to ensure the correct legal procedures are followed.
- Staff understand the reasons for mental capacity assessments and consent and consistently record the patients' capacity to consent to treatment.
- There is a clear governance process in place, which sets out the board composition and reporting and escalation processes, including roles and responsibilities and accountability.
- Governance processes and structures are developed to monitor the quality of care and treatment delivered and actions taken when practice is below expected standards. This to include all aspects of care provided, records written and management of medicines.
- Create a system to empower staff to speak out about any concerns without fear of reprisal.

Outstanding practice and areas for improvement

- Develop and implement systems and processes to regularly review risks which impact on the care and treatment of patients ensuring that risks are identified, escalated, controlled and mitigating actions are monitored.
- A review is undertaken to ensure arrangements are fit to support the delivery of high quality care where external contracts have been implemented, particularly in medicine supplies, RMO contracts and IT services.

Action the provider SHOULD take to improve

The provider should:

- Develop systems to ensure staff follow infection prevention and control procedures and ensure all equipment, including hoists, are cleaned between patient use.
- Carry out hand hygiene audits are completed regularly and outcomes shared with the clinical teams.
- Provide a women only day room for detained patients.
- Ensure there are systems and processes in place for recruiting suitable agency staff, including DBS checks.
- Have staff available to provide stimulating activities to enhance the patients' rehabilitation experience.
- Develop a vision for what it wants to achieve and workable plans to turn it into action. Staff, patients, and local community groups should be involved in developing a shared vision for the service.
- Ensure there are relevant and up to date policies and procedures based on national guidance and best practice, that are readily accessible to all staff.
- Encourage senior managers review the staff survey and develop actions to improve the experience of staff employed at the hospital.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment (1) All premises and equipment used by the service provider must be – (a) clean, (e)properly maintained How this was not being met: The equipment and environment were not being safely managed and put patients and staff at risk. We found repairs were being carried out in house by staff without the relevant qualifications. We found a fire exit boarded up blocking escape, and we found at times there was insufficient equipment to safely care for patients. We found equipment had not been serviced in line with recommendations. We were told by staff and patients that rooms and equipment was often left uncleaned and we found no cleaning logs to provide evidence that areas had been cleaned. Servicing of ward equipment was overdue and there was no system to ensure equipment was available and fit for use. Regulation 15 1(a) (e)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment of the service users must only be provided with the consent of the relevant person. (3) If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act. (4) But if Part 4 or 4A of the 1983 Act applies to a service user, the registered person must act in accordance with the provisions of that Act. How this was not being met: Patients detained under the Mental Health Act 2015 did not receive regular clinical review and systems were not in place to ensure the correct legal procedures were followed. Staff did not understand the reasons or mental capacity assessments and consent and there was no consistent recording of mental capacity assessments and actions taken. Managers reviews were not taking place as required under the MHA code of practice. There were no systems or processes in place to ensure referrals to tribunals were happening. Regulation 11(3)(4)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. (a) assessing the risks to the health and

This section is primarily information for the provider

Enforcement actions

safety for service users of receiving the care or treatment. (b) doing al that is reasonably practicable to mitigate any such risks. (C) ensuring that persons providing care or treatment to service users have the qualifications, competence skills and experience to do so safely (g) the proper and safe management of medicines (h) Assessing the risk of and preventing, detecting and controlling the spread of, infections, including those that are health care associated.

How this was not being met:

There were no robust systems or processes to identify, monitor or evaluate mandatory training, and compliance data was not captured for all staff groups. Mandatory training compliance was below the service' target in some areas and ineffective for non-English speaking staff.

We were not assured there were robust systems and processes in place for safeguarding or that all staff understood how to protect patients from abuse. Staff did not receive safeguarding children training, roles and responsibilities and oversight and reporting lines were not clear.

Infection control risks were not well monitored or managed to identify where risks existed. Staff and patients stated hygiene practices were not always followed and PPE was often not used or used inappropriately. There were no cleaning schedules available for clinical areas.

Risks to patients were not always assessed, monitored or carried through to care plans and followed by staff. All patients did not have NEWS charts. The service did not monitor safety effectively or use results well. Staff did not routinely collect safety information across all wards, or share it with staff, patients and visitors. We found no evidence to show managers used this to improve the service.

Staff did not always keep accurate records of patients' care and treatment. We were not assured that records were always up to date or truly reflected the patients' needs.

The management of medicines at the hospital was not safe and there were problems with the supply of

Enforcement actions

medicines into the service. There was no clinical pharmacy oversight or service to support medicines management which increased the risk of errors. Incorrect medicines were often arriving at the hospital and prescriptions were not managed safely and relied upon increased checking by nursing staff.

Regulation 12 (2)(a)(b)(c)(g)(h)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 1) systems or processes must be established and operated effectively to ensure compliance with the requirements in this part.(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services) (b)assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity (d) Maintain securely such other records as are necessary to be kept in relation to (i) persons employed in the carrying on of the regulated activity and (ii) the management of the regulated activity. (e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services (f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e). How this was not being met: There was no formalised board or governance structure. Roles and responsibilities were unclear and reporting lines were not clearly identified.

This section is primarily information for the provider

Enforcement actions

There was no evidence of discussion about dashboards or quality indicators. Risks were not identified appropriately or reviewed regularly with mitigating actions. We saw audits had been completed but actions to improve poor practice had not been identified.

Staff felt unable to speak up, or contribute to any improvement actions and feared for their jobs if they made comment.

Contracts with external organisations were not reviewed or evaluated, and gave no assurances of how they would meet the needs of the service.

Regulation 17 (2)(a)(b)(d)(e)(f)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements (2)(a)persons employed must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. How this was not being met: There were not enough staff with the right qualifications, skills or competency to safely care for patients. We found shortfalls in staffing against national recommended staffing levels. There was a high reliance on agency staff, many of whom had a poor understanding of English. This meant they did not always interpret care plans accurately or complete records appropriately. Training provided for these staff was in English and could not be assuredly understood. Staff and patients found communication difficult with these agency staff. The service did not have systems and processes to make sure staff were competent for their roles. Some training in specific skills for roles was provided but managers did not ensure these were attended by all staff.

This section is primarily information for the provider

Enforcement actions

Regulation 18 (1) (2)(a)