Glenside Manor Healthcare Services Limited

Pembroke Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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

This inspection took place on 7 and 15 November 2018 and was unannounced. Pembroke Lodge is one of the six adult social care locations. Up to sixteen people can be accommodated at the home. Glenside Manor Healthcare Services is not close to facilities and people may find community links difficult to maintain.

At the time of the inspection, there were three people living at Pembroke Lodge. It is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Staff said the unit manager "often pops in" to the home. The staff were not aware who was the registered manager. The staff on duty told us this registered manager rarely visited the home.

In December 2016 the provider told us that the service was not accommodating people and was "dormant". The provider failed to inform the CQC that the regulated activity of accommodation for people who require nursing or personal care at Pembroke Lodge was reinstated in July 2018. Although we asked the provider to resubmit a notification to lift dormancy, we have not received this.

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.

Quality assurance systems were not effective. Audits were not robust and did not provide an accurate assessment of the quality of care delivered. Action plans were not developed to drive improvements. The CQC was not kept informed of accidents and incidents reportable under the Care Quality Commission (Registration) Regulations 2009: Regulation 18.

People were not safe from the risk of potential harm. Risk assessments were not clear on the actions to minimise the risk. There were people who expressed their frustration and anxieties using behaviours that staff found difficult to manage. Documentation about these incidents did not show behaviour management plans were always followed. Records of incidents were not detailed and did not include the actions taken to manage difficult behaviours. Staff told us they were not confident to use MAPA holds. MAPA (Management of Actual or Potential Aggression) programme teaches management and intervention techniques to help staff manage escalating behaviour in a safe manner.

Recruitment procedures did not ensure the staff employed at the home were suitable to work with vulnerable adults. The CQC received whistleblowing concerns about staff not being able to speak basic English and that agency staff were working without appropriate checks. These agency staff were working at Pembroke Lodge to maintain staffing levels. There were some agency staff that were working across locations including Pembroke Lodge that did not have the appropriate disclosure and barring checks or references in place. Relatives also expressed concerns about staff not able to speak or understand basic English. These relatives said their family members were at risk of harm because these staff were not able to understand instructions.

The CQC received whistleblowing concerns about the competency of the staff undertaking maintenance checks of systems and equipment. These findings apply to all Glenside Manor locations including Pembroke Lodge as systems checks and repairs were carried out by the same maintenance staff. The CQC requested proof of the competency of these staff from the provider. The documentation provided did not give CQC reassurances that staff undertaking maintenance checks were skilled or competent.

There were insufficient staff employed to deliver continuity of care. Five staff were employed to work at the home. However, five staff were not sufficient to maintain staffing levels. The staffing rota included a registered nurse on duty during the day and at night. On both days of the inspection a registered nurse and three rehabilitation assistants were on duty. One person had one to one support from staff during the day and another had one to one support throughout the day and night. The staff on duty told us agency staff and staff from other locations were deployed to the home to maintain staffing levels. The registered nurse on duty on 15 November was from an external agency. This registered nurse had worked at the service three times before but not consecutively. This meant the registered nurse leading the shift was not well known to people.

Medicine systems were not managed safely and people were not having their medicines as prescribed. The stock of medicines held did not demonstrate people were having their medicines as prescribed. Guidance to staff was not in place for all medicines prescribed to be taken "as required".

One of the two staff we spoke with knew the types of abuse and to report their concerns. The other member of staff had not attended safeguarding training and was unaware of the actions to take for skilled are made to the local authority, who have the lead in investigating safeguarding concerns, where there are significant concerns about people's health or wellbeing.

Care records were not up to date and guidance was inconsistent for some people. This included people at risk of choking. Mental capacity assessments were undertaken for some complex decisions. However, there was no documented rationale for withholding people's cigarettes and lighter. CQC hospital inspectors had identified one person at the home was detained under the MHA since July 2018. However, all appropriate documentation for this person was not in place. We noted section 3 was discharged the day following the hospital inspection. There were no reports on how this decision was reached. DoLS applications were to be made to the supervisory authority.

People's needs were not assessed before they moved between the Glenside locations and hospital. Personal information was brief where it was documented. Some care plans gave staff guidance on how to care for the person. However, most lacked detail and were not always person centred. People were not involved in the planning of their care. The staff told us they had read the care plans but found them inconsistent. Structured activities did not take place and there were little opportunities for people to develop their daily living skills. One person told us it was "boring" living at the home.

The information received from relatives about raising concerns was not consistent with the complaints log. This did not enable a clear audit of complaints to take place so that improvements could be made or lessons learnt. A relative told us they would approach the staff or the Clinical Commissioning Group (CCG) with concerns.

The CQC received whistleblowing concerns that the boiler was faulty and hot water was not always available to people. During the inspection we saw maintenance staff visiting the home to switch the boiler back on as it was switching itself off. Staff confirmed this and on both days of the inspection, they told us there were times, when there was no hot water or heating in parts of the building.

There was insufficient equipment across sites. During the inspection the staff from another location contacted the home to borrow aids. The staff appropriately refused for equipment belonging to one person to be given.

People had access to healthcare services as required. A relative told us they were kept informed about GP visits and important events.

We saw some good interactions between people and staff.

We found breaches of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The staff were not knowledgeable about potential risks and the action needed to minimise these. Risk assessments did not give staff clear guidance on how to minimise the risk.

Safe systems of medicine management were not in place.

Staff were not knowledgeable about safeguarding procedures.

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

Is the service effective?

Inadequate

The service was not effective.

The needs of people were not assessed as they moved between services.

The provider was not able to demonstrate that staff had suitable skills, were supported and received training to ensure they could meet the needs of people.

People's health needs were assessed and were supported by the GP to stay healthy.

Staff were not knowledgeable about people's abilities to make decisions.

Is the service caring?

Requires Improvement

The service was not always caring.

One person told us the staff were "sort of caring". The staff spoke about people in a caring and respectful manner. Staff raised whistleblowing when they became concerned about people's

safety and welfare.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care plans were not always person centred and did not reflect people's current needs. People were not involved in the planning of their care.
People had little opportunities to pursue interests and hobbies.

The log of complaints across the Glenside site was not reflective of comments made by relatives across the Glenside locations.

Is the service well-led?

Inadequate

The service was not well led

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

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

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

Pembroke Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted by whistleblowing concerns. These involved staff not having appropriate checks before starting employment, language barriers of staff, poor working and living conditions for staff working as agency staff, competency of staff undertaking maintenance checks and lack of equipment across the Glenside Manor site.

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

This inspection was carried out by two inspectors and took place on 7 and 15 of November 2018 and was unannounced.

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.

One person agreed to give us feedback. The other person we asked refused to give feedback about their experiences of living at Pembroke Lodge. We contacted two relatives and one responded to our request for feedback. We spoke with the unit manager, registered managers from other locations, registered nurses and rehabilitation assistants including senior rehabilitations assistants. We also spoke with the office manager, quality and safety lead, HR assistant, maintenance staff, night manager, catering staff and chef.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included two care plans in detail. We reviewed the staff duty rosters, policies and procedures and quality monitoring documents.

Inadequate

Is the service safe?

Our findings

This inspection was brought forward because of the concerns made to CQC about staffing. These concerns related to people being at risk of harm as staff were working without the appropriate disclosure checks such as references and disclosure and barring checks. Other concerns raised were about inappropriate use of Management of Actual or Potential Aggression (MAPA) holds as staff were not trained to use restraints. The CQC was also told about insufficient and faulty equipment and the competency of the maintenance staff. We followed up these concerns at the inspection. Where appropriate, we passed information to relevant agencies and raised safeguarding alerts to the local authority.

We found concerns regarding one person who had a Do not attempt resuscitation (DNAR) in place. This was because there was inconsistent guidance on resuscitation. One care plan stated the person was for resuscitation but a DNAR order found in another file stated that the person should not be resuscitated. We spoke to the staff on duty and they were not clear if this person should be resuscitated. Three staff did not know the decisions to take in the event of an emergency and said they would have to check the care plan. Another member of staff said they thought the person was to be resuscitated and would give this information to medical staff in an emergency. This person was at risk of being given inappropriate life sustaining treatment which went against their personal wishes and medical advice. This concern was raised with a senior manager but no immediate action was taken. This unit manager left to attend a meeting on site without giving appropriate guidance to the staff on duty nor was the care plan updated. We raised a safeguarding alert for this person.

We reviewed an incident report dated 9 October 2018 which had occurred in another Glenside Manor locations. The incident report described that two of three staff had used medium to high level MAPA holds. 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. This 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 increases 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. We raised a safeguarding alert for this person.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicine systems were not safe. The training matrix included one registered nurse and showed this registered nurse had not updated their skills or knowledge on the safe administration of medicines. Accurate records of medicines to be administered were not maintained for the people living at the service. For example, the staff had documented instructions regarding missing medication administration records (MAR) on a record that was not for the same person. The staff had noted that the MAR were missing for two people. This meant a record of medicines administered was not in place.

Accurate and up-to-date records of medicines in stock was not maintained. The quantities of medicines received were documented on the MAR for some people which the staff making the entry had signed. However, there was no record of medicines carried forward. For example, on the 13 November seven tablets to treat insomnia were supplied for one person. We counted five tablets in stock on the 15 November 2018. The MAR showed that staff had been administering this medicine since the 5 November 2018. This meant there was no accurate balance of medicines in stock. Another person was prescribed a medicine to treat anxiety. However, this medicine was not in stock.

The quantities of medicines in stock showed people were not having their medicines as prescribed. For example, the care plan for one person stated that 250mg of an antipsychotic medicine was to be administered. The directions on the MAR was for 200mg to be administered in the morning and 50mg at 6pm. We noted that 150 tablets of 25 mg were remaining. This meant there were more 25mg medicines in stock than if the person were having their medicines as prescribed. The registered nurse on duty was not able to give us an explanation for this.

The MAR detailed the antidepressant prescribed to another person and in stock were 100mg and 50mg tablets which made the 150mg dose. The MAR with a start date of 5 November indicated that none of the 100mg and 50mg tablets were supplied. MAR charts had been signed since the 5 November as administered. The number of tablets in stock indicated the person was not having their antidepressants. We checked the stock of antidepressants for this person and over four months 112 of the 100mg were supplied 92 were in stock.

MAR charts were not always signed to show medicines had been administered. For example, the MAR was not signed to show the medicine was administered on 9,10 and 11 November 2018 for one person prescribed with medicines to reduce gastric acid. The MAR had not been completed to show the reasons for not administering the medicines.

Procedures were not in place for medicines prescribed to be taken "when required" (PRN). There were people prescribed with medicines for anxiety and for pain relief. Protocols that detailed the signs that people needed PRN medicines were not in place. Protocols were not devised detailing the order multiple pain relief options were to be administered. The directions for one person prescribed with PRN medicines to treat psychoses was for staff to inject 50mg stat (immediately) as instructed by prescriber. This person was also prescribed with multiple PRN medicines to reduce anxiety. The lack of PRN protocols increased the risk that the persons anxiety would not be managed consistently.

People were prescribed topical creams and ointments, including paraffin based emollients. During the inspection we observed people smoking that were prescribed with emollients but PRN protocols were not in place on the safety precautions to be taken. Topical daily charts were in place to record when topical creams and ointments were applied. While the directions were brief, body maps illustrated where on the body the cream and ointments were to be applied.

Safe systems of medicine disposal were not in place. We found a plastic bag of medicines for one person in the medicine cabinet. A note in the container stated "Medication surplus to be returned as no longer required. Don't have any recording charts for medicines for returned stock." The name of the person on the document was not the same as the medicines in the container. The registered nurse on duty told us they were from an agency and were unaware of why the medicines were in the cupboard.

Where action was taken to address individual risks, documentation was not clear or coordinated. One person was assessed at risk of choking following an incident where they choked on a food item. This person

also had a specific health condition that meant their swallowing ability could continue to decrease. The person had been reviewed by the speech and language therapist (SaLT) working on site on 22 October 2018. There was guidance from the SaLT on high risk foods and how these should be served to minimise the risk. This guidance was recorded in the person's daily records but unless staff read past entries the information would not be seen. A care plan written on the same day as the SaLT assessment did not contain all the guidance that had been given. The care plan did give staff guidance on the risk foods to be avoided and to cut food into bite size pieces. However, on the first day of our inspection, we observed the person was eating food assessed as high risk, which had not been cut into bite size pieces, as per their care plan. One staff told us, "[person's name] should not be having toast and it should have been cut up."

On the first day of the inspection we saw the information board in the kitchen did not reflect this person's dietary needs and it stated they were on a normal diet. On the second day of our inspection after raising this with staff, we saw it had been changed to bite sized food. Staff who were not familiar with this person would not have guidance available to safely mitigate the risks to them.

On the second day there were four staff on duty, three regular staff and one agency. None of the staff on duty knew the SALT recommendations, or that this person was a choking risk. One staff told us the person was fine to eat alone, which should not happen regardless of the choking risks, as they received one to one staff support. Another staff said, "I did not know anything about this and I have been giving him food he could choke on." Staff were visibly upset when talking about the person. However, the person had been left vulnerable and put at increased risk of choking. A safeguarding referral was made for neglect and was to be investigated by the lead local authority in safeguarding adults.

Therapeutic intervention for people that presented with difficult behaviours were not effective. People living at the home had experienced brain injury and for some people this had triggered changes in their behaviours. A re-assessment of people's behaviour management plans had not taken place, before their transfer from the Glenside hospital. Behaviour management plans were not developed using information gathered about the person's preferred routines. For one person their personal information stated "to relax they had a bath". This strategy was not possible to implement due to the lack of hot water at the service

The behaviour care plans and strategies for the same person gave guidance for staff to allow the person to "pace around wards" and referenced the hospital unit and not the home. The care plans for personal care and behaviour, were inconsistent with each other. For example, the personal care plan stated staff must "encourage the person to make choices" and staff must "offer him a choice from two options." The behaviour plan stated, "do not offer [name] multiple options of clothes". The recorded rationale was because "it appeared to overstimulate the person". This meant there was a risk that staff would approach this person needs inconsistently increasing the risk of the behaviours escalating

The recording of behaviours showed the staff were managing difficult behaviours towards other people and staff. Some behaviours included "damaging the environment and throwing objects at staff" as well as inappropriate behaviours that placed staff at risk of harm. Staff were not always confident in managing these behaviours. [when people used behaviours to express their anxiety and frustrations.] One staff told us "I am not powerful, they are too strong for me, I am frightened sometimes. I can't do the MAPA holds as they are too strong, I feel scared." Other staff told us that one person was very precise about how routines were to be completed. These staff said they felt "scared" and not able to manage these situations.

Reports of behaviours that staff found difficult to manage lacked detail. This included information about the incidents, how the person was supported during the incidents and the follow-up action taken, such as reviewing the care plans. For one person, 12 episodes of "physical aggression" towards staff were

documented between 1 and 15 November 2018. Most incidents had occurred during the delivery of personal care. However, recording about the actions taken, was not detailed. For example, offering pain relief as pain was an identified trigger. Medicine records showed pain relief and medicines to reduce anxiety were prescribed but not administered. How the staff managed the situation and the follow up action such as reviewing the care plan was not documented. This meant there were inconsistent approaches from staff on how they managed difficult behaviours due to lack of accurate guidance.

We observed that staff were completing one to one care with two people and they received this throughout our inspection. The risk assessment in place for one person was clear and stated when behaviours had been shown and what had been done to monitor these behaviours

Incidents and accidents were not always managed appropriately. One person had experienced 14 falls since April 2018. The risk assessment on the falls care plan had not been completed. The moving and handling and falls care plans showed conflicting information and it was not clear what measures had been taken as a result of these falls. In August 2018, this person fell and sustained a cut to their forehead. It stated they were seen by medical staff but there was a lack of detail in the care plan. The manual handling risk assessment in place had not been completed properly. It stated this person was at medium risk but the documented score was eight, which was actually a low risk according to the risk framework in place. There was a danger that if the risk level was not being recorded properly, the risk was not being mitigated appropriately.

Infection control was not always managed appropriately. We observed Pembroke lodge was visibly clean. Staff told us they completed daily tidying and housekeeping staff were employed to clean. We saw gaps in the cleaning schedules. For example, the cleaning domestic cupboard had not been checked since 4 November and was meant to be done daily. The cleaning schedules were not dated and did not confirm the direction that bedrooms were cleaned daily. One staff said, "The cleaners hardly come and we end up having to do it." Another staff said concerns had been raised about not having access to the right equipment. They told us mop heads had been taken away but they still had to clean up after episodes of incontinence.

During the inspection, one of the hospital units rang and requested to have us of a person's shower chair. The registered nurse explained that it was a specific person's shower chair and would not be appropriate to be used by another person. The service took the decision to refuse the request but told us they were short of this type of equipment on site.

We received anonymous concerns regarding faults with the heating. We contacted senior managers before our visit to gather information. CQC was informed that the boiler was to be repaired and that people were offered alternative placements when the heating was not operating effectively.
The registered nurses confirmed on both inspection visits dated 7 and 15 November that the boiler was not working and there was no hot water. On the first day of our inspection it was not working and staff had called in external contractors who attended. The staff had to abandon the kitchen due to fumes from an oil change. When we returned for a second day of inspection the hot water was still not working. Staff told us there was a difference of opinion between managers on the safe repairs of the boiler. Staff told us the maintenance staff had to visit the home each time the boiler switched itself off. We noted maintenance staff visited twice on both days of the inspection to switch the boiler back on.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment of new staff was not safely managed. There were some staff working across site without the

appropriate disclosure and barring checks or references in place. There was no evidence of interview questions that had been asked and some staff did not have contracts in place. Some of the files we checked did not have any record of previous employment or the qualifications and skills a staff member had. The recruitment agencies and not the employees previous place of work had provided the written references which meant the satisfactory evidence of conduct from the previous employer was not provided.

There had been a significant turnover of staff in the last 12 months and some staff confided they were unhappy and also considering alternative employment. The HR assistant told us 240 staff across the Glenside Manor and hospital had left in 2017. Staffing levels at Pembroke Lodge were maintained with agency staff and with various staff from other locations within the site. This meant continuity of care was not provided to people with complex needs. Staff felt this compromised the safety of people. A member of staff told us the staffing levels were "poor" and support was sought from other locations to maintain staffing levels. The agency registered nurse on duty on 15 November 2018 told us they had previously worked three separate shifts at the home which were mainly at night. They told us their handover was from a regular agency registered nurse. Due to this they did not know the needs of the people they were supporting well.

Sufficient numbers of staff were not employed to ensure people's needs were met. The CQC requested the staffing list for Pembroke Lodge under Section 64 of the Health and Social Care Act 2008. We noted that five staff were employed to work at the home. However, the number of staff employed were not sufficient to maintain staffing levels. A registered nurse and three rehabilitation assistants were on duty during the day as two people were receiving one to one support. At night there was a registered nurse, one rehabilitation assistant and an additional member of staff to carry out one to one support.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us they felt safe living at the home. A relative told us since their family member had moved to the home they felt more reassured about their safety. One member of staff told us the procedure for safeguarding. This member of staff told us the types of abuse and the actions they must take where they had concerns.

Inadequate

Is the service effective?

Our findings

We received anonymous concerns about language barriers with some staff. Senior managers told us during previous discussions that language lessons were to be provided to staff who were not able to communicate effectively in English. On speaking to staff, it was clear that some staff employed through recruitment agencies were not able to speak or understand English. This had a significant impact on the care provided. One staff commented, "Some staff don't speak English and use google translate, it's not safe." Another staff said, "I am fine with speaking, I talk all the time but I have a problem sometimes, I want to try, I do writing when I am off. I speak with people ok."

Staff also told us they were unable to communicate with the maintenance workers on site and had to go through the maintenance manager who was based in Kent. Relatives and people using the service also told us the difficulties they had in communicating with staff. The information provided by the provider showed that language lessons had been provided but did not show which staff had attended these. Staff told us that while lessons had been provided these were not well attended and to date these had not had any effect or impact on the standards of care provided

New staff did not always receive a thorough induction. We checked five staff files and a checklist of induction topics covered, was attached to one. There was no evidence to verify that the remaining four had an appropriate induction to prepare them for the role they were employed. We were informed that not all staff had received an induction or mandatory training due to their lack of fluency and understanding of the English language which would impact on the staff's ability to understand any training provided.

Staff were not supported to undertake their roles and responsibilities due to lack of training and one to one supervision from the line manager. Records did not confirm that all staff were having one to one supervision with their line manager. The minutes of the supervision meetings that had been completed were not in the system although registered managers were expected to send copies of one to one supervisions to the training manager for audit reporting. A rehabilitation assistant told us one to one supervisions were with the line manager. A rehabilitation assistant recalled they were due to have a one to one supervision on the 7 November with the registered nurse.

We checked five staff files and for one member of staff there was a record of one to one supervisions. The last time this staff had a documented supervision was in 2015. We looked on the provider's electronic system and saw this person had received a supervision in September 2018 None of the other staff had any supervisions recorded in the system. Not all staff that we spoke with were aware of when they had last received a supervision.

The 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. The staff were not fully trained to meet the needs of people. The training matrix included the names of four staff although the staff list included the names of five staff. The training matrix showed that mandatory training was attended by 42 percent of nursing staff, 68 percent of rehabilitation assistants and 85 percent of staff delivering "direct care".

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Staff were not knowledgeable about gaining consent and supporting people to make day to day decisions. The training matrix provided showed that two of the four staff included in the matrix had attended MCA training. A rehabilitation assistant told us they had not attended any MCA training. This member of staff told us some people made day to day decisions but one person received checks to ensure their continence. This member of staff was not certain on what actions to take if the person refused. Where there were language barriers, staff struggled to understand our questions on decision making. One staff member told us, "I have heard of capacity, I work with [person's name], I am unable to explain what it means, I don't know what this is." One person told us "I make my decisions, about when I get up and go to bed, and what I want to eat." Where people had capacity to make specific decisions, we found restrictions had been imposed. Agreements in relation to the restrictions were not documented or reviewed. For example, people who smoked had their cigarettes kept in the staff office.

Assessments were not in place on the rationale for withholding cigarettes. There was no method of monitoring how many cigarettes people had left to safeguard their property. For one person their care plan stated that it was imperative that whenever they chose to smoke, they were given access to their cigarettes. Staff told us they followed the care plan and a member of staff told us this person was capable and safe to keep their own cigarettes with them.

We saw a consent to share and collect information had been put in place in May 2018 for one person. However, this documentation was incomplete and had not been signed or completed.

There was conflicting documentation about the person's capacity to make specific decisions. There were parts of the care plan that stated one person did not have capacity and was unable to contribute to the care plan. For other more significant decisions capacity assessments had deemed this person to have full capacity. For example, this person was deemed to have capacity for life sustaining treatment without first assessing their impairments and considering medical history.

Decisions about future nutrition and hydration wishes were reached before it was medically appropriate to assess one person's capacity. The staff were assessing people's capacity to make decisions before it was necessary. A mental capacity assessment for alternative nutrition and hydration was completed in July 2018 despite this person being able to eat and drink normally. The mental capacity assessments that deemed the person having capacity to have feeding tubes and formed part of the person's advance care plan. This meant staff were not clear on when specific decisions were needed to be made.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

Before the second visit dated15 November 2018, we received information from colleagues in the hospital inspection directorate. Hospital inspectors told us all required documentation was not in place for people

detained under the Mental Health Act (MHA). Daily notes dated the 9 November 2018, confirmed that the section three order was discharged for one person at the home that day. This order was discharged the day following the inspection visit and the unit manager was to apply to DoLS instead. There was a lack of documented information about how this process had been assessed and the decisions reached.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Arrangements were not in place to ensure people received consistent and coordinated support when they were referred to and moved between locations. Admission procedures were not followed. For example, the Access to and Discharge from Glenside Services appendix 14 section for Transfer and Discharge stated, "manager will visit the people and conduct an assessment of their needs to establish whether the admission criteria have been met using the Manager Re-assessment document". Re-assessment documents were not in place for people that transferred between locations.

People's concerns about moving between services was not considered before clinical staff made decisions about their care and treatment pathways within Glenside services. Care plans were not updated or reviewed when people transferred between Glenside locations. The minutes of a clinical meeting dated 18 October 2018 for one person stated, "funding has been agreed. He will move as soon as possible. Maybe tomorrow." Daily reports detailed that this person moved from the hospital unit to Pembroke Lodge the following day 19 October 2018. There was no evidence available to show that this person or their relatives had been consulted fully about this move. Daily notes for this person on the day of their admission stated the person was "distressed and aggressive during personal care."

We received concerns that people were not receiving the therapies that were promised before their admission. The Statement of Purpose for Glenside Manor dated 2017, details its aims as, "to provide rehabilitation and support to help people return to the most independent lifestyle possible. The majority of people who undertake rehabilitation at Glenside, return home or transfer into a supported living environment". We saw that care plans discussed the ongoing rehabilitation care that people should receive when they moved to a different location within the Glenside site. However, there was little documented evidence that people were continuing to be rehabilitated. One person who was meant to have regular physiotherapy told us, "The physiotherapist sort of visits."

People were not supported to improve their skills with daily activities. Documentation confirmed one person would benefit from Speech and Language Therapy (SaLT) input to improve their communication skills. We noted the date on the communication care plan was changed to 28 October 2018 the previous day. We saw documented that this person was having input from SaLT because they found verbal communications difficult to understand. Staff were made aware that at times this person used behaviours difficult to manage to communicate. The review minutes dated June 2018 stated, "not active SaLT Input."

Reports of healthcare professional visits were not clear on the nature of visits, the outcome the visit and where there were changes of treatment or guidance. There was a contact sheet in front of the care plan for another person. The names of healthcare professionals involved were detailed and included SaLT, psychologists and physiotherapists. However, there was a lack of details on what the visit was for or what was discussed other than to record the day of the visit.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were registered with a local GP surgery for their ongoing healthcare conditions.

People at the home did not have access to the kitchen. Staff told us people were not allowed access for safety reasons. A four-week rotating menu was in place, but some people chose to shop off site on occasions. The staff then prepared meals of people's choosing in the home's kitchen for meals bought off site. One person said "I buy my own. sometimes I have it from the kitchen, but staff sometimes cook the food I want."

Staff told us there was biscuits and fruit available for people. People also bought their own snacks and had their own cupboard in the kitchen. One person also had a fridge in their room that they kept their own drinks in.

Staff were responsible for maintaining the cleanliness of the kitchen and did this after preparing meals and at the end of their shift. We saw that fridge and freezer temperatures and the temperature of cooked food was taken and recorded.

Requires Improvement

Is the service caring?

Our findings

One person told us the staff "sort of" cared about them. A relative that visits their family member weekly told us the staff were caring.

Before and during the inspection staff raised whistleblowing when they became concerned about people's safety and welfare.

A member of staff told us "I have a good rapport with service user. I try and do as much as I can with resources. If it was up to me I would take them out every day but we don't always have the resources. People have individual time but not every day. House meeting are not taking place." During the inspection we observed staff spending time with people in the lounge and outside when they were smoking. One person told us the staff helped them purchase and prepare their meals.

One person was supported by the staff to communicate using a white board. The member of staff supported this person to tell us about their experiences of living at the home. This person looked for staff support when we struggled to understand their verbal comments. The person accepted staff support and we observed good interaction between them.

The staff we asked told us how they showed compassion towards people. This member of staff said where needed they spent time with people. They stated, "if you know the service user" the signs of distress can be identified.

People living at Pembroke Lode did not always receive person centred care. Issues with the heating and hot water meant that staff were not able to meet the preferences of one person. Staff told us one person become increasingly distressed by the fact they were being unable to have a bath when they chose. Staff told us this had increased the challenges in the person's behaviour. We saw on three occasions in one week this person had requested a bath and staff had to refuse due to the boiler not working. When we arrived on the second day the staff informed us that this person was not happy, as they had wanted a bath but the hot water was not working again. This person told us "I wanted a bath." One staff member told us they were having to boil a kettle to assist the person with their personal care. They felt this was wrong and undignified for people.

The culture in the service was not positive due to the lack of staffing. Staff told us morale was very low and this had impacted on the care provided to people. Support people received was not from regular staff and often care was provided by agency staff. One staff told us "We don't have our own staff group, the people we are supporting have very complex needs and need skilled regular staff and we don't have this."

Requires Improvement

Is the service responsive?

Our findings

Each person had three care plan folders, containing their care plans, assessments, any legal documentation and daily records file. The rehabilitation assistants told us they were responsible for recording events in the daily records and care plans were devised by the registered nurses. Following the inspection, the provider clarified that rehabilitation assistants (RA) were "Responsible for completing 1:1 documentation, as is all staff supporting a person with 1:1, including nursing staff, Registered nurses record events in persons inter-disciplinary folder at the end of each shift, RAs can write inter-disciplinary notes if countersigned by a registered nurse.

People's care plans were not clear or up to date and the focus was not on agreed goals. Care plans were written in the first person despite people not participating in the planning of their care. For one person, behaviour, elimination, mobility, personal and communication care plans stated, "cognitive impairments [name] was not able to understand" and was written in their best interest. We asked one person if they were aware that they had a care plan and they responded, "What's that?"

Care plans were not person centred and contained conflicting information about people's needs. The staff we spoke with told us they had read the care plans but information was conflicting and it was difficult to establish how best to support people.

When people's life stories were gathered the background history, was brief. Where people's likes and dislikes were sought, their preferences were not part of their care plan. For one person the personal information included family network, past employment, hobbies and interests. Also documented was the person, "can become depressed and would go to bed". The section for daily routine stated "loved skin products. Liked showers and to relax a bath". However, the behaviour or personal care plan did not give staff guidance about this.

Care plans were task focused and gave no guidance on people's preferred routines. For one person their preferences were not part of their personal care, elimination, communication or behaviour care plans. Daily notes completed by the staff, focused on tasks and direct care undertaken. Daily notes lacked a person-centred approach and lacked detail on the choices offered to people.

There were limited details on people's choices within their care plans. For example, the personal care plan for one person stated that staff were to promote a structured routine. There were no details on what exactly this structured routine was, or information such as whether the person preferred a bath or shower. We saw that the terminology used in care plans was often inconsistent when referring to people. For example, the word compliant was regularly used, such as "[person's name] was compliant with taking their medication." We saw people were not referred to by name but as "the service user" in care plans which was impersonal. This was also used by some staff when they communicated with each other.

Accessible information standard (AIS) was not always considered for people with communication needs. AIS was introduced to make sure that people with a disability or sensory loss were given information in a

way they can understand. The communication care plan for one person detailed their medical condition. The care plan stated, "finds it difficult to understand verbal language" but the action plan did not give any guidance to staff on how to communicate with the person. The current goals in the diagnosis and background document dated October 2016 stated, "improve visual recognition". The Speech and Language therapist (SaLT) documented in May 2018 that this person benefited from ongoing support. However, in June 2018 staff documented, "no active SaLT input."

A relative told us when their family member was admitted to Glenside Hospital, there were three -monthly review meetings. These meetings were then extended to six monthly and the relative understood they were to become annual. A coordinated meeting where relatives sit and discuss issues with the manager had not taken place. Despite meetings not taking place this relative told us they had been informed when their family member was moving from the Glenside hospital unit to Pembroke Lodge.

Care plans were not devised on how people preferred to pursue hobbies and interests. There was a lack of stimulation or opportunities for engagement. Daily records referred to people's days spent smoking and meeting personal care needs. One person told us "I go for walks, I get bored lots. It's boring here." The behaviour management plan for one person gave staff guidance to develop an activity timetable of meaningful activities. We viewed the most recent activity timetable dated October 2018. For one week there was only one activity listed which was a Halloween party. On the week of 22 October 2018 there was only three activities on the timetable and two of those were half hour sessions with a physiotherapist. One staff member told us, "Three of the activity staff had quit and gone back to care." Staff were unsure who was meant to be doing the activity timetable for this person. This meant the person was not being supported appropriately, which increased the risk of a negative impact on their wellbeing and behaviour.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records were not up to date or accurate. Written handovers were not provided to staff for reference particularly for staff that did not work regularly at the home. The agency registered nurse on duty told us there was a verbal handover when they arrived on duty. This registered nurse had worked in the home on three separate shifts and mainly at night. The staff on duty told us there was one registered nurse who mainly devised the written handovers. The most recent written handover was dated 13 November 2018. The rehabilitation assistants told us a written handover that gave them information about people with do not attempt resuscitation (DNAR) orders and for people at risk of choking for example would be useful.

The paperwork had not been appropriately reviewed or amended to reflect the place people were now living. The care plans had the previous hospital ward on that people had transferred from. In some instances, the previous location had been crossed out and Pembroke Lodge written next to it, rather than updating the care plan. We saw where staff had documented they had reviewed and reprinted some care plans which meant that staff had changed the date and the location.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were provided with a copy of the complaints procedure. The log of complaints provided by the operation director showed no complaints had been received in 2018.

A relative of one person told us the staff made them aware when outings were organised. A member of staff told us they were a legally able to drive the minibus and organised trips.

Inadequate

Is the service well-led?

Our findings

The provider failed to inform the CQC that the regulated activity for Pembroke Lodge was reinstated in July 2018. The provider wrote and told us that from the 13 December 2016 the service was to become dormant as people were not being accommodated. When we became aware that people were being accommodated at Pembroke Lodge we wrote to the provider. On the 8 August 2018 we emailed the provider to make them aware of the procedure to request dormancy to be lifted. We met with senior managers on the 1 October 2018 and made them aware again of their responsibility to inform CQC when dormancy was lifted. We then received an online statutory notification on 3rd October but the document was corrupted. We asked the provider to resubmit the notification to enable this to be processed. However, we have not received a resubmission to lift dormancy.

While a registered manager was in post staff told us the unit manager "often popped in" but the registered manager rarely went to the home.

The staff did not feel valued and their rights and wellbeing were not protected. The CQC has received a significant number of whistleblowing concerns about the leadership of the organisation. On the first day of the inspection we were told there were no senior staff on duty. The staff we spoke with were distressed about an incident that has occurred the previous day, between the provider and senior managers. A member of staff said, "the hierarchy is missing and we feel exposed and vulnerable". Some staff were tearful when they told us about the management of Glenside Manor Healthcare Services.

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

Quality assurance systems were not effective. The 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. These documents included audits that measured the quality of service delivery. Audits that assessed the quality of care delivered were not robust and action plans were not developed to improve care and treatment. Medicine audits for September and October 2018 showed all medicine standards assessed in October 2018 were met. However, these did not include balance checks such as medicines received or in stock. Audits did not assess if documentation was in place for recording medicines no longer required or if there was adequate storage for medicines that required additional storage facilities. In the medicine management audit, the home scored100% for having clean cabinets but keys were not provided for all cabinets in the medicine room.

The care plan review audit did not assess the quality of the care plans. The audit focused instead on people having care plans for specific areas such as personal care and behaviours and that monthly reviews had

taken place.

We received concerns about agency staff working with recruitment agency agreements. This meant people with recruitment agreement were not employed by the provider and were not given contracts of employment. Whistleblowers told us senior managers were unaware of staff working and accommodated within Glenside Manor. At the time of the inspection there were a number of staff on site whose identity could not be confirmed by the most senior staff on duty. During the inspection staff told us there were language barriers, staff were working without appropriate clearances and were not trained to meet people's care. The HR assistant was not able to verify how many staff were accommodated at Glenside Manor or about the clearance checks of all staff working across locations. These findings apply to Pembroke Lodge because staffing levels were maintained by agency staff and staff from other locations.

The provider did not ensure that staff were trained and skilled to meet people's needs. The training matrix requested under Section 64 of the Health and Social Care Act 2008 did not include training attended by the staff working at Pembroke Lodge. The training matrix showed that 68 percent of staff had attended the training provided.

The maintenance of equipment was not managed safely and placed people at risk. Whistleblowers raised concerns about the competency of maintenance staff working and accommodated at Glenside Manor. Maintenance staff were not qualified to undertake the refurbishments, tests and checks they had been undertaking. The maintenance staff were undertaking checks of fire alarm system, boiler checks and legionella. We formally requested proof of competence or qualifications for maintenance staff to undertake maintenance checks. However, the various ID cards provided did not demonstrate the competence of the maintenance staff. For example, the provider gave us details of the maintenance manager's Construction Skills Certificate Scheme (CSCS) card. This card provided proof of training and qualification for work they were skilled to undertake in a construction site. (The maintenance manager had a CSCS card for construction site operative.) This meant the maintenance manager was only able to support skilled staff in a construction site and not qualified We spoke to the maintenance manager on the 7 November 2018 about their competence and were not able to verify their qualification for water safety. This was because the certificate number on the ID card had faded. Due to this we have been unable to confirm that checks have been completed safely. We have referred these issue to a number of other agencies including the fire department.

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

People were not provided with sufficient equipment. During the inspection, staff from The Glenside Hospital for Neuro Rehabilitation contacted the home to borrow a bath chair. The staff told us the bath chair belonged to one person in the home and would not be appropriate to be used by another person. The staff took the decision to refuse the request and told us they were short of this type of equipment on site. These staff told us equipment was often borrowed because there was insufficient equipment for moving people safely. It was also reported that some equipment was out of order.

People and others were not protected from the risk of harm. The CQC requested reports of incidents and

accidents. These documents were not comprehensive and reflective of our knowledge of incidents and accidents on the online system known as GEMS. Whistleblowers told us on the 7 November 2018, the GEM system was not being monitored because the staff were not assigned to review online reporting of accidents and incidents. We saw on the 7 November 2018 where staff had reported equipment failures. Reports of incidents for other locations which included theft and medicine errors were not included in the reports we received on the 22 November 2018.This supports the findings that GEMS was not monitored adequately.

The provider had not notified the CQC of incidents reportable under the Care Quality Commission (Registration) Regulations 2009: Regulation 18. We were not notified of events that stopped the service from operating effectively. Whistleblowers told us the boiler was not working and some areas of the building were cold and there was no hot water. We contacted senior managers on 29 October who told us the boiler was to be repaired by maintenance staff and where people's bedrooms were cold, alternative accommodation was offered. We visited on the 7 November and staff told us the boiler was switching itself off and maintenance staff were re-starting the boiler manually as needed. An external contractor was on site to assess the faults of the boiler. On the 15 November 2018, staff told us there were no changes as the boiler continued to switch itself off. On the 22 October 2018, we were made aware by the Clinical Commissioning Group (CCG) that they had received whistleblowing concerns about Pembroke Lodge not having heating or hot water.

The 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. Documents requested included reporting of accidents and incidents. The "number of incidents and serious incident document, dated November 2017- October 2018", showed there had been two incidents in August 2018 and three in October 2018. The CQC were not notified of these events. Following the inspection the provider told us these incidents were not reportable under Regulation 18.

People with sensory or communication needs were restricted from giving feedback about their care. We received whistleblowing concerns that the complaints procedures had changed. We received whistleblowing concerns that formal complaints were to be in writing only. Staff had been told that an independent complaint adjudication company had advised to only accept complaints in writing. This company's website rightly recommended that "It is best to put your complaint in writing (email or letter) and you should raise your complaint as soon as possible".
CQC was also told by a whistleblower that staff received lots of complaints and the provider would meet with the families concerned. This whistleblower told us the complaints were not being recorded or dealt with properly. Two relatives in another location told us they had made numerous complaints but a record of these complaints were not documented in the complaints log provided. The decision to adapt the complaints procedure applies to all Glenside Manor locations including Pembroke Lodge.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person centred. People did not participate in the planning of their care. Action plans were inconsistent from each other. Staff found care plans confusing and difficult to determine how best to support people. There was little opportunities for people to experience meaningful activities or to pursue hobbies and interests.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Mental capacity assessments were not completed for all restrictions imposed. Best interest decisions had been taken before they were needed. Staff were not knowledgeable about the principles of the Mental Capacity Act 2005.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 Registration Regulations 2009 Notification of death or unauthorised absence of a person who is detained or liable to be detained under the MHA Records were not accurate or up to date Quality assurance systems were not effective. Audits did not focus on all areas of care delivery and action plans were not in place on driving improvements.

The enforcement action we took:

Impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe systems of medicine management were not in place. Staff were not knowledgeable about people's individual risks. Risk assessments were not clear on how to minimise the risk. Staff were not following guidance on how to manage difficult behaviours when people expressed their frustrations and anxiety. Care plans and risk assessments were not reviewed following incidents of difficult behaviours. This meant staff were not consistently managing or minimising difficult behaviours. The staff were not confident to use behaviour management techniques. People needs were not assessed before they transferred to other locations within the Glenside Manor site. People were not receiving the rehabilitation programme in line with the aims of the organisation.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were at risk of abuse. The staff were not knowledgeable about safeguarding procedures. People's wishes on life saving treatment wishes was inconsistent. Where people had specific care and treatment needs the staff were not adhering to guidance.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Recruitment procedures did not ensure the staff employed were suitable to work with adults at risk. New staff did not receive an induction to prepare them for their roles. Staff were not trained to meet the needs of people. Staff were not supported to undertake their roles and responsibilities. Staff that carried out maintenance equipment checks were not competent to undertake these checks. Insufficient numbers of staff were employed to maintain staffing levels. Where the provider had links to recruitment agencies these staff were used to maintain staffing levels. However, there were language barriers with agency staff due to them not able to understand or communicate instructions. The provider said they were to provide English language lessons. The CQC was not provided with certificates to evidence that agency staff were helped to improve communicating in basic English.

The enforcement action we took:

Warning Notice