Glenside Manor Healthcare Services Limited

Limetree

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
Limetree provides care for adults who require long-term nursing intervention and support because of an acquired or traumatic injury, or other neurological condition.

Limetree is one of six adult social care locations at Glenside which also has a hospital that is registered separately with CQC. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

One adult social care location (Pembroke Lodge) is currently closed as there were ongoing and continual issues with the provision of heating and hot water.

The hospital was also closed due to a flood caused by a major water leak. Patients from the hospital were transferred at short notice to some of the adult social care locations. Works to repair the fabric of the hospital building were currently underway. As Limetree was temporarily accommodating people from the hospital we reviewed aspects of these patients care and support in line with the expectations of their inpatient status. The ground floor at Limetree was being used to accommodate hospital patients with the upper floor for those people accommodated under the Adult Social Care (ASC) registration.

The provider notified us of the temporary arrangements for hospital patients while refurbishments were taking place. However, Limetree will not be correctly registered with CQC if these arrangements become long term. The provider will need to submit applications to CQC to register appropriately if the closure of the hospital continues.

People's experience of using this service:
The service was rated Requires Improvement at the comprehensive inspection dated August 2018. The rating for the focus inspection undertaken on the 7 November 2018 remained the same.

People and patients were placed at risk from poor management. We found systemic overarching poor management systems and improvements were not prioritised. There had been sudden and persistent changes of senior managers. There was a lack of regulatory response from the provider. There were poor recruitment procedures, and a lack of investment with equipment and maintenance of the property. The

morale of the staff was low and they were reluctant to give feedback because of fear of reprisals. This had an impact on the care people received.

On the first floor we found:
•□People were not receiving continuity of care from staff recruited to work permanently at Limetree. We checked the staffing rota's and saw that agency staff were used on a regular basis when the service was short staffed. Staff from other units at Glenside were also required to provide support to Limetree. The unit manager explained that there was recruitment taking place, however there were delays in recruitment.

•□The service did not have a registered manager in post. The service was being managed by an interim manager. The unit manager was not supported by the provider to ensure they could focus on making improvements in Limetree.

•□The staff were not skilled in supporting people whose behaviour changes were triggered by brain injuries. One person displayed behaviours that the staff team found too challenging to manage effectively. Staff told us that they had colleagues who were scared of the person and they would "hide in other people's bedrooms" to avoid them. There were risks to the safety of people and staff due to staff not being able to support the person effectively.

•□Medicines records were unclear as to why a sedative-hypnotic was administered. While the medicine could cause the person to be more compliant with their care the notes for the following day confirmed that the person remained in bed for most of the following day.

•□People we spoke with were happy with the care and support the received. One person said, "This is the best place I have lived. The staff are marvellous."

•□People's care plans included their preferences and usual routines. Guidance from health and social care professionals was incorporated into the care planning.

On the ground floor for the hospital patients we found :

•□People were not kept safe as staff did not follow systems and processes to identify and act on harm. We identified one person who had bruising. No recent safeguarding referrals had been made. There was no evidence that robust action had been taken by staff in response to the bruising.

•□Guidance was lacking on how staff were to respond accordingly to risks. Records for one person with diabetes showed their blood sugar levels in the evening were frequently above a normal range. We asked a nurse on the unit how they knew what the person's normal blood sugar range was, they told us it was in the diabetes care plan. We checked the care plan and this information was not recorded.

•□There were areas of the home that were not sufficiently secure for people detained under the Mental Health Act. These individuals were placed at risk of potential harm due to a number of items not securely stored. These included items that could have posed a ligature risk. We found a door to a smoking area unlocked that should have been locked which meant others were able to leave and enter the home freely. In the smoking area we found glass greenhouses which were a risk to these patients.

•□We saw where risks had not been consistently mitigated. We saw examples where incidents were reported but should have been entirely avoidable. For example, we found concerns documented in patient records that had not been recorded as incidents, for example the missing lead from a patient room, which could present a ligature risk.

•□There were incidents where staff had not managed situations correctly. We saw two incidents where staff had refused patient's a drink of their choice which had both escalated into deteriorating behaviour and meant both patients required restraint.

•□There was little evidence to show how standards of cleanliness and hygiene were maintained. There was no process, checklist, or audits completed within the organisation relating to infection control. Safety systems were not implemented to protect patients effectively from communicable diseases or to maintain infection control and hygiene. Staff didn't always decontaminate their hands immediately before and after every episode of direct contact. Staff were not always bare below the elbow.

•□Staffing levels were not adequate. Patients who were to receive 1:1 care did not always get it.

•□People's individual care records, including clinical data, were not written and managed in a way that kept people safe. Information needed to deliver safe care and treatment was not available to relevant staff in a timely and accessible way. Care plans were not always updated as the provider required. Nursing assessments and documentation were not in keeping with standards for nursing.

•□Medicines were not always safely managed. The service did not always make sure that people had their medicines recorded appropriately. For one patient who was an insulin dependent diabetic, we found four prescription charts in use, which presented a risk of medications being missed. There were good security processes in place, as both the prep room (where drugs were stored) and the drugs cupboards themselves were locked and secure.

•□There was little emphasis on the safety and well-being of staff for example when staff were pregnant. Staff did not feel valued. Staff told us that staff were very negative about the provider and this caused friction among staff. Also, as patients from the hospital had been transferred to other wards, not necessarily their speciality, staff felt there were unrealistic expectations placed on them for patient needs outside their scope of experience.

•□Staff told us they had no confidence in senior management as there was no communication, however, the newly appointed CEO was perceived as someone who would listen to the staff.

•□Staff were concerned that the hospital (which was closed due to a flood) would not re-open and their jobs would be at risk.

Rating at last inspection:
This service was rated Requires Improvement at the comprehensive inspection dated 30 August 2018. Due to the concerns identified the rating from this inspection is now Inadequate

Why we inspected:
This inspection was brought forward due to information of risk or concern; following the last comprehensive inspection, in October 2018, CQC have received on going whistleblowing concerns. After the last inspection CQC requested assurances from the provider about the action they would take to improve the service. To

date these assurances have not been forthcoming. We did not inspect the key questions Effective, Caring and Responsive because ongoing monitoring did not raise any information about risks or concerns in these areas.

Enforcement:
Following the focus inspection in November 2018 we imposed a condition on the providers registration. The provider was required to submit monthly improvement action plans to CQC from February 2019. We also issued four warning notices following the focus inspection at Glenside Hospital in November 2018.

Follow up:
The rating of the service is Inadequate. We therefore placed the service in Special Measures. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. We will have contact with the provider and registered manager following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below

Limetree

Detailed findings

Background to this inspection

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

The inspection was prompted in part by whistleblowing and the lack of ongoing assurance that the required improvements were being implemented following the last inspection.

Inspection team:
The inspection of Limetree was completed by one inspector for the people accommodated under the service Adult Social Care (ASC) registration and a hospital inspector for those people who were in patients. A team of inspectors inspected the other locations which are situated on the same site.

Service and service type:
Limetree is a 'care home' for 26 adults with acquired or traumatic brain injury, or other neurological conditions. 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 not in post. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The home manager told us they were to apply to us for registration as manager

Notice of inspection:
The inspection took place on the 13 March 2019 and was unannounced. At the time of the inspection there were 26 people accommodated which included 13 patients temporarily placed from the hospital.

What we did:
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.

This inspection included speaking to one person, the home manager, a registered nurse and rehabilitation assistants. We also spoke with catering staff. We reviewed records related to the care people received. We looked at records of care plans, daily report, and staffing rotas. Records that relating to the safety and suitability of the service were reviewed. We looked around the property.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

The provider failed to report on the actions to meet Regulation 12 of Health and Social Care Act 2008 following the inspection dated August 2018. At the focused inspection dated 7 November 2019 we repeated the breach of Regulation 12. There were insufficient improvements to show compliance as well as further breaches of this Regulation.

For people supported under the adult social care registration:

Systems and processes to safeguard people and staff from the risk of harm; assessing risk, safety monitoring and management

•Accidents and incidents were not always reported to the unit manager for them to review. We found one incident where a nurse had been "punched in the head twice" by a person. This had not been reported for the unit manager to review. We informed the unit manager, who was not aware of the incident.

•The staff were not confident in managing behaviours that were extreme. Risks to people's safety were identified and assessed, these were included in their care plans for staff to follow. However, staff told us guidance was not followed for one person when they presented with extreme behaviours due to their brain injury. Staff told us there was a lack of confidence when supporting people with behaviours that were deemed to be challenging. Different staff said that some staff "hide in other people's bedrooms." This was to avoid contact with the person. One staff member said, "I am worried that someone is going to get seriously hurt." This was because they felt they could not rely on all staff assigned to working on the unit to be supportive.

The above concerns demonstrated a failure to prevent avoidable harm or risk of harm which is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received safeguarding training. Staff told us they would feel confident identifying and raising concerns with the unit manager and that action would be taken.

•People had a Personal Emergency Evacuation Plan (PEEP) in their care plans. The PEEP explained what support the person required in the event of an emergency evacuation.

Staffing and recruitment
•The unit manager was responsible for all parts of the recruitment process, due to shortfalls in the human resources department. Due to other workload requirements, this had caused a delay in progressing applications to recruit permanent staff. The unit therefore relied on agency staff and staff from other units at

Glenside supporting people in Limetree.

•□Staff told us that staff from other units did not have the training, experience, or knowledge to support each person's behavioural needs safely.

•□The unit manager told us they would always have enough staff who have received MAPA training available. MAPA stands for Management of Actual or Potential Aggression. MAPA is a set of skills and protocols to support a person to a calmer state, and to receive care interventions. Some people on Limetree required staff to perform MAPA holds, a form of restraint to ensure people and staff safety while care interventions are carried out.

•□Two members of staff told us they were usually responsible for completing MAPA holds on one person. They said this was because other staff and staff attending from other units had either not received the training or were not confident.

•□Staff rotas showed that the service mostly operated in accordance with their staffing numbers, as per people's assessed needs. These were nine staff members in the day and six staff members at night, with at least one nurse always on duty. Staff informed us that this was not always the case. The unit manager explained that at times of emergency sickness, or when agency staff were not available, the unit would operate with less staff.

•□The unit manager was scheduled to meet with the chief executive officer to discuss the requirement for additional permanent staff and support with recruitment.

Using medicines safely
•□Medicines were mostly managed safely, however there were two areas where the information held by the service lacked clarity.

•□The diabetes care plan for one person and their medicines records did not explain what their normal and safe blood sugar levels should be before their evening meal. The nurse advised us that this was recorded in the care plan, however it was not. This meant that the person received the same level of insulin each evening, regardless of their blood sugar levels. There was no guidance in place for staff to follow and identify if the person's blood sugar was too high before administering their insulin.

•□The records of 'as and when required' (PRN) medicines administration for one person's sedative-hypnotic did not contain enough detail. There was a PRN protocol stating that the medicine should be administered when the person was experiencing difficulty sleeping and if they were displaying agitation. The nurse on duty explained that the reference to agitation was because this could be an indicator that the person was tired. However, the person also had medicines for agitated behaviours, if other support techniques did not work. We saw two records for the week before the inspection where the administering nurse had recorded that the person was "resistive to care" and they had then administered the PRN to aid their sleep. This was administered at 11pm both days and there was no explanation of what other support had been offered or tried, to evidence that this protocol was followed and the action was appropriate.
The above concerns demonstrated a failure to prevent avoidable harm or risk of harm which is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□Medicine audits were completed by the unit manager.

Preventing and controlling infection
•□•□The unit manager explained that there was a member of domestic staff assigned to working in Limetree five days per week. They also told us that a cleaning supervisor was available for any issues to be reported to and to that they completed compliance checks.

Learning lessons when things go wrong
•□The unit manager was keen to receive feedback to aid service improvement.
The unit manager had a quality improvement plan in place.

For people supported under the Hospital registration:
•□Systems and processes to identify and act on harm were not followed. We checked one set of patient notes where it had been identified on multiple occasions through skin charts, that there were areas of bruising to different parts of the body. There was no annotation in the notes relating to any action taken and a safeguarding alert was not considered by staff. We raised this with managers, and made an urgent safeguarding alert to the local authority for this patient. We identified a further two cases where harm had been identified but not acted upon and those patients were also referred to the local authority safeguarding team. We found that no progress had been made to strengthen the safeguarding systems and processes in place since the last inspection in November 2018.

•□Despite staff comments regarding reporting incidents we saw where a missing lead that could present a ligature risk was not reported. We found documented in patient record that a lead was missing but this incident had not been reported. Staff told us they understood how to report incidents through GEMS the online reporting system. However, they could not recall any incidents recently reported. Staff told us learning from incidents was shared at handover but could not give specific examples.

•□We saw examples where incidents were reported but should have been entirely avoidable. For example, there were two incidents where staff had refused patient's a drink of their choice which had both escalated into deteriorating behaviour and meant both patients required restraint. We did not find that these incidents had been prevented, despite staff knowledge of the triggers for these patients, and we did not find they had been adequately addressed. We found that learning from the incident had not occurred with the staff involved.

The above concerns demonstrated a failure to prevent avoidable harm or risk of harm which is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Cleanliness, infection control and hygiene
•□There was little evidence to show how standards of cleanliness and hygiene were maintained. There was no process, checklist, or audits completed within the organisation relating to infection control. We spoke with two housekeepers and although they were aware of processes to clean clinical and non-clinical areas, they could not evidence what they had cleaned and when different rooms or equipment was cleaned last. There were no cleaning logs in place. The ward sister showed us a cleaning schedule. This was just a list of areas to clean and did not show whether the cleaning had been undertaken.

•□We observed a housekeeper mopping a patient's bedroom and the floor was left very wet. This member of staff walked away to mop the corridor. The inspector prompted the housekeeper to place a wet floor sign in the bedroom. However, they had limited understanding of English and the inspector had to point out the sign.

•During our time on the Limetree unit there was a patient who was suspected to have Methicillin-sensitive Staphylococcus aureus. Staff did not know how best to manage this patient's needs as there was no infection control policy which identified best practice. Staff resulted to using internet searches to identify how to care for this patient, which resulted in the patient unnecessarily being barrier nursed. We discussed the need for barrier nursing for this patient with the registered medical officer (RMO), who told us the patient did not need to be barrier nursed; this information had been given to staff the previous day, but had not been communicated on to the day staff. We were told there was a nurse with responsibility for infection control at the service, but they were on holiday.

•We saw examples of poor hand hygiene. Members of staff were not always following good standards of hand hygiene immediately before and after every episode of direct contact or care as required by National Institute for Health and Care Excellence Quality Standard 61 Statement three. While staff thought that a patient required barrier nursing, staff were not consistently using personal protective equipment such as gloves and aprons. We observed one member of staff in the patient's room who was not wearing gloves or an apron, and we observed them leave the room without washing their hands. When we challenged this, we were told the staff member had just popped in, which indicated a lack of understanding of the principles of barrier nursing. Despite having raised this with the staff, we saw that staff continued to not use personal protective equipment.

•Most of the Limetree Unit was physically clean. However, there were some examples of equipment with 'I am clean' stickers on which were several weeks old. We found that clinical preparation rooms appeared clean, as were storage cupboards.

•People were placed at risk from the spread of infection. Staff were not always bare below the elbow. We saw staff wearing a wrist watch, rings with stones in and costume jewellery, including a pendant necklace. Also, some staff did not wear the correct uniform as several members of staff were wearing jeans and trainers. This was against the providers uniform policy.

•The arrangements for managing waste did not always keep people safe. We found domestic rubbish bins throughout did not have lids and were open.

Environment and equipment

•The maintenance of facilities and premises did not keep people safe. We found a number of areas where maintenance was required, for example in one bedroom the toilet had come away from the wall. Staff thought this had been reported but were not sure, and told us they had resolved the issue by moving the patient to another room.

•We also found in one room on Limetree a visibly dirty radiator cover on the floor which could be picked up and used either as a weapon, or as a method of barricading the door. Several unlocked rooms contained piles of patient's possessions on the floor in bags and boxes which were not appropriately or securely stored. Amongst these items which were accessible to other patients, we found leads and other items which could be a ligature risk.

Assessing and responding to patient risk

•Staff were not able to identify and respond appropriately to changing risks to people who use services. A set of notes was reviewed in depth. Observation of vital signs were not consistently recorded on the observation chart. Observations were sometimes recorded on the "HDU" (high dependency unit) form.

However, the HDU form was not designed to record observations. This prevented identification of trends in the observations.

• There was confusion on the systems used by the home to identify signs of deterioration. During our last inspection, we were told all patient observations were recorded using the NEWS system, and were stored electronically; we were unable to review these at the last hospital inspection due to the IT system being out of use. During this inspection, we were told the National Early Warning System (NEWS) was not in use at the service and never had been; observations were not recorded electronically and there was no set process in place to manage the risk or identification of deteriorating patients. The doctor we spoke with was not familiar with NEWS.

• We asked a doctor what the expectation was for monitoring observations and we were advised that every patient regardless of condition, should have as a minimum two recorded sets of observations each day. When we asked where these would be recorded, the doctor was not able to locate the observations for the three sets of patient records we were reviewing. We found observations recorded sporadically in one set of patient notes, but could not find any recorded in the other two sets. There was no policy in place to guide staff as to how to monitor, record or manage patient observations.

Mitigating Risks:

• Comprehensive risk assessments were not devised for people who use services and risk management plans were not developed in line with national guidance. We reviewed several sets of patient notes and found that the management of risks was not being properly identified or monitored.

• Skin assessments for suspected pressure ulcers was not in line with NICE clinical guideline 179, pressure ulcers, prevention and management. We found that risk assessments were being completed but found they were not based on a validated scale to support clinical judgement or decision making. Pressure ulcers were also not being categorised to guide ongoing preventative strategies. This meant that staff were unable to properly care for patients and identify if mitigating actions were effective. We found that because of this, there was no identification of pressure ulcers being reassessed if they got worse or better which meant that mitigating actions were in place when they may not have been necessary. Skin assessments identified where patients needed to be repositioned and patients who were identified as being high risk was not being documented. Therefore, we were not assured that patients were being repositioned in line with NICE clinical guidance 179. The service did not use any form of wound charts to monitor progress or deterioration.

• We reviewed a set of patient notes where the medical staff had identified through a risk assessment that the patient required 2000ml of water daily. In the notes we found that on no occasions since the instruction was given (23 days) did staff ensure that the patient had enough to drink. On eight occasions in 23 days, the patient had less than half of what was required and on two days it was not recorded that the patient had had any fluid intake at all. This had not been escalated or acted upon.

• We reviewed a set of patient notes where they were living with insulin dependent diabetes. There was an insulin support plan, which said 'nursing staff should use clinical judgement, and increase blood sugar monitoring if they feel it's needed at the time, any concerns and nursing staff should contact RMO'. We found there was no clinical plan for the patient, or record within the patient's notes which identified if the patient's blood sugar levels were changing and there was no validation system to identify if a patient was at risk of harm. There was no scoring system which allowed staff to identify trends and we found that although there was a feeding regime, it was not being documented properly. This meant that we were not assured the patient was being cared for safely. This patient had experienced over 30 episodes of low blood sugar in

January 2019 and these had been mostly reported as incidents, however we could not see that appropriate action had been taken to refer this patient to specialists to control the blood sugar levels. We found during the last month, there were gaps in recording blood sugar levels, and on two occasions, we found insulin had not been documented as having been given as per the prescription. Staff told us this would have been given, but not properly documented. There was insufficient guidance for staff in terms of managing this patient's diabetes. We raised a safeguarding referral for this patient to the local authority.

• The provider did not ensure that staff understood the process for accessing resuscitation equipment. The Limetree unit did not have its own resuscitation trolley but was kept in a different part of the site. We asked one member of staff about resuscitation equipment who did not know where it was or how to get it. The unit had defibrillator machines but we found them to be kept behind a locked office door. We were advised the process had recently changed but we were not assured that in the event of an emergency, all staff would know how or where to locate the resuscitation trolley.

• Patients did not receive support from the appropriate staffing levels. Patients assigned to receive 1:1 care did not always get it. A patient who was identified as requiring 1:1 supervision was able to, unsupervised, barricade themselves in their room. This was a risk to the patient as the staff were unable to open the door and provide care if required. This incident which occurred during our inspection, was due to this patient being incorrectly barrier nursed and told they could not leave their room. This had distressed the patient, who had then been left unattended and was able to put furniture up against their door. We asked how the staff had explained the reasons for them not being able to leave their room, and we were told staff had printed off a leaflet from the internet to explain to the patient. The risk of this patient's behaviour escalating had not been considered. Staff told us this patient did not like to be in their room for long periods, but they had not reviewed the patient's care plan to mitigate against this.

• Ligature risks were not considered or managed. We found in a number of areas, items which could be ligature risks. In the day room we found phone chargers plugged in and left on the table, and in some unoccupied patient rooms we found wires and leads stored on the floor, which were accessible to patients at risk. In one set of notes we reviewed for a patient who was a potential suicide risk, there was a note to say a lead had gone missing. Staff had looked for the lead, but had been unable to find it. The action had been to increase monitoring to 15-minute checks, and to advise the relative to complain about the missing lead. This had not been reported as an incident, and we did not feel sufficient action had been taken to minimise the potential risk to this patient.

Medical staffing

The units were covered by local GPs who visited weekly although a GP was on call daily. Staff could also call on the RMO if needed. Out of hours medical cover was provided by the 111 service.

Records

• Nursing assessments and documentation were not in keeping with standards for nursing. We found nursing notes were recorded inconsistently. Previous notes were not filed in date order but bundled into an envelope in the notes. This meant that notes to chart a patient's progress were not readily available to staff, for example, agency staff.

• Information needed to deliver safe care and treatment was not available to relevant staff in a timely and accessible way. Each patient had five colour coded folders. Staff could access information well although this would prove confusing for a temporary member of staff.

•□Generally, for notes we found that records were incorrectly filed, some charts were missing and there was duplication of recordings. Charts did not always have the correct patient information on them, i.e. the patient's name. Social activities were not documented well. One patient had three activities dated 25 April, 3 and 5 May but no year. For a patient being discharged that day the documents were not in order and vital signs were not recorded in a way that allowed trends to be identified

•□Care plans were not always updated as the provider required. The provider required all care plans to be updated for changes and reviewed monthly. Care plans should then be archived and replaced with a new care plan every six months as a minimum. We found this was not done. We found a care plan for a patient for postural management (planned approach of the interventions which impact on an individual's posture and function). This had been last updated and reviewed in September 2017. A feeding regime prescribed by a dietitian had not been reviewed since April 2017. From the care plans, we could not be assured patients received up to date care.

•□Peoples individual care records did not keep people safe. The provider was not following NICE quality standard 14 statement 12 which states that patients should experience coordinated care with clear and accurate information exchange between relevant health and social care professionals. For each patient there were up to six different records, all of which were used by multiple staff for different purposes. There were a number of forms and sheets for each of these notes relating to patient care. As a result of this there was no way to ensure that all information was accessible at once, meaning no one had overview of a patient's entire pathway of care. We asked several staff from the nursing and therapies team to give an overview of the patient and found they were not able to do so. One member of staff said, "The only thing I know about this patient is what I write down myself".

•□We found that in some patient records there were pages which did not have an identification sticker on which meant that if they sheet got lost, there would be no way to know which patient it belonged to. There were also loose sheets of paper stored in the notes which meant they were easily lost and out of order. There were multiple care plans and risk assessments in the documents which meant there was a risk of a member of staff following the wrong plan. In places handwriting was illegible and staff were struggling to work out what instructions or updates to care plans and actions.

•□We found that some patient notes were not stored securely as they were in an unlocked cupboard in an unlocked office. This meant that patients or visitors were able to access confidential information that did not belong to them.

•□We found that records audits were not completed by the service consistently. There were audit processes in place to check one set of notes per month. However, this only looked at the presence of documents, rather than its content.

Medicines

•□The provider did not always make sure that patients had their medicines recorded appropriately. The prescription charts were a series of pieces of paper which were filed in a haphazard manner in patients notes. This could potentially lead to patients not receiving or missing medicine.

•□ For one patient who was an insulin dependent diabetic, we found four prescription charts in use, which presented a risk of medications being missed. On each chart there were medicines crossed out or amended, which made them difficult to read. We found the prescription for insulin was not correctly written. It stated

the patient should have between four and ten international units of insulin, but no further instruction in terms of reference to the sliding scale. For this patient we found there were three sliding scales forms in a plastic wallet in the patient record, and not with the prescription chart. None of these sliding scale forms had been signed, and on one, we found the doses to be given had been crossed out and altered, without any signature. We could not find any correlating instructions in the patient record, or any explanation as to why the ranges had been altered by hand, from those prescribed. This meant there was a significant risk that staff may use the wrong sliding scale, or could be administering a dose that had not been properly prescribed.

The above concerns demonstrated a failure to prevent avoidable harm or risk of harm which is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Inadequate:There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

•The provider failed to report on the actions to meet Regulation 12 of Health and Social Care Act 2008 following the comprehensive inspection dated June 2018. At the focus inspection dated November 2018 we took enforcement action and imposed conditions on the registration of the provider which related to Regulation 17 Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. . While we found that some improvements had been made these were insufficient in all areas.

•After the last inspection we met with the provider. At these meetings the provider gave assurances that improvements would be implemented and that an action plan would be submitted. At this inspection we found that the improvements had not been implemented in line with these assurances.

•CQC imposed a condition on the providers registration (part of our enforcement pathway) following the last inspection. This condition required the provider to submit monthly actions plans form February 2019 to us. These action plans had not been received.

•At the last inspection for the hospital site four warning notices were issued. Action had not been taken to meet these warning notices.

•There was partnership working with external agencies including Clinical Commissioning groups (CCG's) and Local Authorities who purchase care for the people who live at Glenside. We were told that the CCG and Local Authority had sought assurances from the provider in the form of contract monitoring meetings and subsequent requests of an action plan. These action plans were to detail how the provider was to improve the service delivery. Action plans had not been submitted despite repeated requests from the CCG. The CCG have told us that they were currently reviewing the care needs of people across the whole site. In response to these reviews alternative placements were being sought for some people as well as patients. CQC continue to work with other agencies to ensure the safety of people

•At this focused inspection we found continued breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•A registered manager was not in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'.

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was in the process of deregistering and a home manager had been appointed.

•□Robust action plans were not developed to meet the conditions imposed by CQC. The home manager had recently developed an action plan for Limetree in order to address the concerns found at our last inspection. The Chief Executive Officer (CEO) confirmed the home manager had shared the action plan for review and agreement. However, the provider had not shared the enforcement actions imposed by CQC. Contractual agreements with partner agencies on how standards of care were to be adhered to were not made known to managers. It is unclear therefore how the manager could have considered all the remedial action required when developing the action plan.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

•□There was a lack of communication and oversight between the provider and senior management at the Glenside site.

•□We found the senior management team was not stable at Glenside since October 2018. Some staff felt there had been too many changes in management and they weren't clear who they could go to and who they could trust. One member of staff told us, "[Provider] is the main man and makes all the decisions. Chief Executive Officer (CEO) can try and put things right but [provider] can stop her if he disagrees".

•□Following the focused inspection dated March 2019 we were told that the new CEO had left employment at Glenside. This follows the dismissal or resignation of the previous senior management team during November 2018 and the subsequent deregistration of all registered managers for Adult Social Care (ASC) locations. All the ASC locations were being managed by unregistered managers. This turnover of senior management has adversely affected the stability of the service and the implementation of the improvements that are required.

•□At the time of the inspection there was staff confidence in the actions of the newly appointed CEO. Staff described the CEO as caring and believed that actions being taken were improving the service. Comments included: "I get very good support from [CEO] recently. It has been crazy. Things have settled quite a lot" and "[CEO] is making things better. Very caring about us and the patients. She comes if we need her".

•□There had been a significant turnover of staff in the last 12 months and some staff confided they were unhappy and were considering alternative employment. At the comprehensive inspection, in November 2018, we found that 240 staff across the Glenside Manor and hospital site had left since 2017. After this inspection we were informed of the resignation of a number of other staff across the site. This high turnover of staff impacts on the morale of the remaining staff; raises concerns about the continuity of care to people using the service and calls into question the culture of the service which some staff described as "bullying".

•□Hospital Staff did not feel supported, respected and valued by other members of the team elsewhere on site. Staff told us that staff were very negative about the provider and this caused friction among staff. Also, as patients from the hospital had been transferred to other wards, not necessarily their speciality, staff felt there were unrealistic expectations placed on them for patient needs outside their scope of experience. For example, rehabilitation needs for patients with psychiatric issues rather than physical illness.

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

Regulations 2014.

• Despite the concerns about the overarching management systems staff had confidence in the home and ward managers and felt listened to and supported. The staff told us the home manager was approachable and always made time for staff and people.

• The unit manager understood they had a responsibility to notify CQC of reportable accidents and incidents. They explained that they had been in their role since January 2019 and were growing in confidence about what should and should not be reported.

• There were improvements in the person-centred care people received. At the last inspection we raised concerns that people were not accessing the community. At this inspection we observed people being supported to go into Salisbury. One person had to tend to some errands, with the support of staff. Another person chose to go to lunch at a local pub, with a staff member.

• The unit manager had a clear vision about what they wanted to achieve and knew the improvements that were needed. Their workload was stretched due to requirements to achieve deadlines in evidencing improvements were being made. This was while not being supported by efficient central services, such as human resources and maintenance.

• The unit manager had started to complete audits on a monthly-basis. They knew the outcomes of the audits and had taken action where shortfalls had been identified. The audits included those for care planning and medicines.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; continuous learning and improving care.

• The permanent staff we spoke with were clear about their roles but explained their concerns that staff from other units that were required to work on Limetree were not. These concerns had the potential to impact the safety of people and staff.

• The unit manager explained that they had encouraged the team to be more involved and to share their ideas about how the service could be improved. They explained that they sought staff feedback through meetings, supervision, and through having an open-door policy.

• Staff told us they could go to the unit manager for advice and if they needed to discuss any concerns. They described the unit manager as approachable, fair, knowledgeable and friendly.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	There was a failure to ensure the effectiveness of quality assurance systems. Systems and processed that protect people were not in place. Audits were not robust and action plans were developed to improve the quality and safety of the services provided. This is a continued breach.

The enforcement action we took:

There was a failure to ensure the effectiveness of quality assurance systems. Systems and processed that protect people were not in place. Audits were not robust and action plans were developed to improve the quality and safety of the services provided. This is a continued breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	There was a failure to ensure the effectiveness of quality assurance systems. Systems and processed that protect people were not in place. Audits were not robust and action plans were developed to improve the quality and safety of the services provided. This is a continued breach.

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