Glenside Manor Healthcare Services Limited

Langford/Kennet

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

At the inspection dated 14, 15 and 20 June 2017 this service was rated as Requires Improvement. We found the service had not complied with Regulations 9 and 12 of the Health and Social Care Act Regulations 2014. We found that support plans and associated care records were not person centred. Potential risks were not always identified and appropriately addressed. Following the inspection, the provider wrote telling us how compliance with Regulations 9 and 12 were to be met. At this inspection we found there had been some improvements but there were other breaches of regulation.

We inspected Langford and Kennet on the 11 and 12 June 2018. The inspection was unannounced on the 11 July 2018 and the provider was aware of the inspection visit on 12 July 2018.

Langford and Kennet 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. It is one of seven adult social care locations situated on one site, known as Glenside. The site also contains a hospital, which is registered with us separately.

At Langford and Kennet complex nursing care can be provided for up to 16 people with neuro-degenerative or previous brain injury. At the time of the inspection, there were 16 people using the service. Eight people were living at Langford and eight people were living at Kennet.

A manager was in post and in the process of becoming registered with CQC. 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.

This is the second consecutive time the service has been rated Requires Improvement.

Quality assurance and audit systems were not robust and did not cover all areas of care provided. The local improvement plan had identified shortfalls and all actions identified for improvement were met. For example, in October the action plan to develop person centred care plans and "ME" documents were met. However, during this inspection we found that some actions identified as met in the improvement plan remained unmet.

Audits were not used to assess all areas of service delivery. For example, when we asked about infection control audits we were told they were not necessary. This was because the issues were already known and actions were documented on meeting minutes. Although risk assessments detailed how risks were mitigated, the risk scores were misleading. Assessments and monitoring of risk may not be promoted due to low scoring for people at greatest risk. This meant that the provider may not have been alerted to emerging

risks.

The staff used an online system for reporting accidents and incidents. Although safeguarding referrals were made for reportable abuse the provider had not notified CQC of all incidents. The manager reported to CQC in retrospect all incidents that affect the health, safety and welfare of people who use services.

Medicine systems were not managed safely and people were not having their medicines as prescribed. One relative said one person had not received their medicines on time for three consecutive days. We found gaps in the recording of medicines administered, some prescribed medicines were out of stock and there was a lack of clear guidance on administering "when required" medicines. Where medicines were to be administered outside recommended guidance there was a lack of confirmation from a pharmacist about these medicines. For example, medicines to be crushed. Some errors had not being reported. The staff that applied topical creams were not signing the Administration of Topical Medicine charts these were being signed by registered nurses. The manager told us the supplying pharmacist did carried out visits 12 months after the start of the contract. A meeting with them was arranged and this will be raised.

Clinical care plans were detailed. Some care plans were person centred but needed to be further developed. Relatives were invited to reviews. People said the permanent staff knew their preferences and how to meet their needs.

The manager told us how continuous learning was used to drive improvements. For example, introduction of lead roles for staff in their area of interest, such as tissue viability and safeguarding to ensure staff have a point of contact.

Housekeeping staff told us while recruitment of new staff was in progress there had been better deployment of resources to ensure better cleaning regimes. However, we observed there were areas of the property in need of repair and redecoration. For example, the walls behind beds were worn and had chipped paint.

People felt safe because they had confidence in the staff. The staff we spoke with said they had attended safeguarding adults training to help them recognise the signs of abuse and how to report their concerns.

We found staff available to people during the inspection. While relatives said there were improvements, they had raised concerns about the reliance on agency staff. The staff told us there were measures in place to ensure agency staff were not on duty without permanent staff. This promoted continuity of care.

Where possible people made their own decisions and relatives said they were consulted. In Kennett and Langford mental capacity assessments and best interest decisions were in place for all restrictive practice.

People and relatives were positive about the skills of permanent staff. The staff told us the training provided by the organisation was good and there were opportunities for professional qualifications.

People had access to healthcare services as required. Two relatives raised concerns about the lack of physiotherapists which had led their family members to having restricted movements. Staff said the provider had promised that everyone would have physiotherapy but this had not happened. The registered nurses contradicted these comments and told us physiotherapists had visited recently to assess people and a regular physiotherapist was assigned to the home.

When we asked people if staff were kind and caring they said "excellent" and "brilliant". We found activities to be an area of real strength. The staff were responsive towards people's Equalities Diversity and Human

Rights (EDHR) in relation to their diet and culture.

The complaints procedure was on display and a suggestions box was available for written feedback and suggestions. Staff told us people "tell us first" about their concerns or they were emailed.

We found a breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicine systems were not safe. We found gaps in the recording of medicines administered, some prescribed medicines were out of stock and there was a lack of clear guidance on administering "when required" medicines.

Risks were identified but the score given to the level of risk was not consistent with all documentation that related to the same risk. Members of staff were knowledgeable on actions necessary to reduce risks.

There were sufficient staff to support people and we observed that staff were visible and available to people at different times of the day. However, there was a heavy reliance on agency staff.

People said they felt safe and could describe what safe meant to them. Staff attended safeguarding of vulnerable adults training which meant they knew how to recognise the types of abuse and how to report their concerns.

Is the service effective?

Good

The service was effective.

Staff enabled people to make choices. People's capacity to make complex decisions was documented.

The staff had the skills and knowledge needed to meet the changing needs of people.

People's dietary requirements were catered for.

Is the service caring?

Good

The service was caring

People were treated with kindness and with compassion. We saw positive interactions between staff and people using the service. Staff knew people's needs well and how to reassure them when they became distressed.

People's rights were respected and staff explained how these were observed.

Is the service responsive?

Good

The service was responsive

Care plans were written in the first person and had aspects of person centred care. Clinical care plans were detailed. People told us the staff knew their needs and how to deliver care in their preferred manner.

People had access to in-house and community activities. People were supported to maintain contact with relatives.

Is the service well-led?

Requires Improvement

The service was not well led.

Quality assurance systems and processes for assessing the delivery of care were in place. However, not all the findings of this inspection were identified for improvement.

The views of people were gathered from feedback surveys and meetings.

Staff were aware of the values of the organisation. They said the team worked well together.

Langford/Kennet

Detailed findings

Background to this inspection

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

This inspection took place on 11 and 12 July 2018 and was unannounced on 11 July 2018. The provider was aware of our visit on the 12 July 2018.

The inspection was carried out by two inspectors and an expert by experience over two days. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed all the information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

We spoke with four people and six relatives. We spoke with the manager, two senior nurses (ward sisters), four senior rehabilitation assistants, two rehabilitation assistants and two agency staff. We also spoke with housekeeping and catering staff. The operations director, clinical lead and quality safety patient lead were part of the inspection. We received information by email from the quality and safety patient lead.

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 six care and support plans. We reviewed the staff matrix provided, staff duty rosters, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of the day.

Requires Improvement

Is the service safe?

Our findings

At the pervious inspection dated 14, 15 and 20 June 2017 we rated Safe as Requires Improvement. We said the staff were not assessing risks, to where possible, mitigate the risks identified. Following this inspection, the provider wrote to tell us the actions that was to be taken to meet the requirements of the legislation. The action plan stated the actions were to be met by 30 September 2017.

At this inspection we found some improvements were made regarding assessing risks. We found care plans contained risk assessments for areas such as falls, mobility, skin integrity and malnutrition. These assessments were regularly reviewed. When risks were identified, the plans guided staff on how to reduce the risks. For example, moving and handling plans detailed the hoist and sling that staff should use and other information specific to the person, such as supporting parts of the person's body when moving them.

For some people the score given to the level of risk was misleading. For example, A Waterlow assessment which estimates the risk of people developing pressure ulcers, had placed one person at high risk. This was due to poor mobility, age, continence and neurological needs. However, the tissue viability risk assessment had placed them at low risk. The tissue viability risk assessment for this person listed the actions to minimise the risk of them developing pressure ulcers. For example, monitoring the integrity of the skin. However, the section for assessing the level of risk was confusing and did not give prompts on how to score the risk. For example, there was no description on how to make judgements on the "likelihood" or "severity" of the risk. This meant the judgements on the level of risk was based on staff interpretation of what "likelihood" and "severity" meant to them. Due to the incorrect scoring we could not be assured how the provider was monitoring and mitigating the quality and safety of people at greatest risk.

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

Medicines were not always managed safely. We looked at all the medicine administration records (MARs). We identified 15 gaps where staff had not signed to confirm they had administered people's medicines during June 2018. There was nothing documented to indicate that staff had noted the gaps, or that any action had been taken to check if the medicines had been given. This meant the provider could not assure themselves that people received their medicines as prescribed.

Medicine errors were not always identified and action taken to prevent reoccurrences. On the day of our inspection we highlighted a potential medicines error. One person had been prescribed pain relief skin patch every 72 hours, but staff had signed the MAR on two consecutive days on 18 and 19 June 2018. We discussed this with the manager who was unaware of the incident. They said it had not been picked up during the latest medicine audit.

One person was having their medicines crushed and given by mouth in yoghurt or a drink. However, the instructions on the MAR did not specify it was safe to do this. Crushing medicines can alter their mode of action and pharmacist advice should be sought before doing this. We noted an agency member of staff had

not administered the medicine because instructions were not clear. We discussed this with the Nurse in change during the inspection and they immediately contacted the pharmacist to ask for confirmation in writing.

Some people were prescribed additional medicines on an as required (PRN) basis. However, because there were no PRN protocols in place there was limited information to inform staff when and why these might need to be administered. We discussed PRN protocols with staff on day one of our inspection in relation to the administration of anti-anxiety medicines and on day two protocols had been put in place. They included details of signs people might display and what action staff should take before resorting to the use of medicines. However, although protocols for the use of anti-anxiety medicines had been put in place, there were no protocols for the use of pain relief. This was of particular relevance because some people using the service were unable to communicate when they had pain. The service regularly used agency staff, therefore there was a risk they would not know the signs to observe for that could indicate people were in pain.

Although staff had signed to confirm when they had administered PRN medicines, they did not always record the reasons why they had done so. This meant it would be difficult for staff to easily identify whether the original cause of the pain had been resolved or any trends or triggers.

Some people had been prescribed topical medicines such as creams and lotions. Some people at the service were not able to express when they were in pain. There were limited instructions in place for when and where these needed to be applied. For example, one person was prescribed a lotion for use "as a moisturiser." The MAR had only been signed on three days during the last four-week period which indicated the lotion had not been applied. Because of the lack of instructions, it was difficult to assess if there had been enough applications. There were no topical administration records in place for care staff to sign to confirm they had been applied. Instead nurses signed the MAR. This meant that they were signing the charts to confirm application when they hadn't actually been part of this procedure.

Medicines were stored safely. Clinical room and medicine fridge temperatures were monitored. Controlled medicines were stored safely. Regular stock checks of controlled medicines were undertaken. However, stock balances of other medicines were only checked when a new supply of medicines was received. This meant the service was unable to easily ascertain if the current stock levels were accurate or not.

People had not received their medicines as prescribed. MARs showed that some people had not received their medicines as prescribed because they were out of stock. One person was prescribed a medicine to control seizures and for three consecutive doses had been omitted because there was no stock. Another person's eye gel had not been given for seven days for the same reason. The nurse in charge told us there were ongoing issues with the pharmacy used to supply medicines. A relative commented that their family member had not received their medicines for 48 hours because the medicines were out of stock.

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

While the risk ratings were confusing in Kennett the staff we spoke with knew individual risks and the actions needed to minimise risks. A member of staff told us to support people with mobility needs they had attended training in relation to safe moving and handling techniques. They said textured meals were served for two people at risk of choking and people at risk of pressure ulcers were assisted to reposition regularly.

Incidents and accidents were reported and investigated. Records showed lessons were learned when things went wrong and measures were introduced to prevent recurrence. Examples included staff being retrained

and care plans being updated.

People told us they felt safe living at the service. One person told us, "Yes, I feel safe – they are all very friendly. The environment makes me feel safe". Relatives told us their family members were safe. Their comments included "Yes, she is safe because there are so many staff around so the possibility of her being threatened is extremely low – she is a lot safer here than where she was before" and "Yes, he is definitely safe". Staff said they were trained to recognise abuse and knew how to report it. Comments included, "If I saw bruises, I'd report it to the nurse immediately" and "I would always report it. It's important to do it immediately so that it doesn't get missed." Staff also said they felt confident to raise any concerns about poor care. One said, "My priority is the people who live here. I'm not scared to speak up."

Sufficient numbers of staff were on duty at all times in Langford and Kennett. The rota in place showed there were three registered nurses, two senior and five rehabilitation workers working across Langford and Kennet. The manager said one member of staff covered twilight hours and at night there were two registered nurses on each unit with one rehabilitation worker.

Staffing levels were maintained using agency and relief staff. The relatives we spoke with raised concerns about the reliance on agency staff. The staff we spoke with agreed agency staff were used to maintain staffing levels. They said the same agency staff were booked to provide continuity of care for people.

The manager told us how language barriers were addressed when comments were made about people not understanding staff whose first language was not English. The manager told us, "during interviews the candidates language skills are noted". Once staff were appointed and during "shadowing with more experienced staff their skills are considered more closely." Where there were issues the staff were, "registered on language courses which was reviewed".

Systems to protect people from the spread of infection had improved A housekeeper told us the deployment of staff was better managed while recruitment was taking place. We saw that housekeepers had allocated days in each location within the Glenside site and in between these times there was a schedule for cleaning priorities such as bathrooms and toilets. The manager told us rehabilitation assistants also had some responsibility for maintaining people's bedrooms clean. We found the property to be clean. However, we observed there were areas of the property in need of repair and redecoration. For example, the walls behind beds were worn and had chipped paint.

We observed staff using personal protective equipment. Toilets had guidance on hand hygiene and there were hand gels available within each unit.

Good

Is the service effective?

Our findings

People's needs were met by staff that were skilled and whose performance was monitored. One person told us, "I think staff know how to care for me. The staff here have the right skills. It is nice here. They remembered it was my birthday". A relative told us, "All the regular staff have been wonderful, and have shown so much care that [name] seems much more responsive and relaxed." Another relative said "They are definitely effective."

The staff we spoke with commented positively on the quality of training they received. Comments included, "The training is really good. The trainer is also really good; we can ask questions without feeling stupid" and "The training is very good." One agency worker confirmed they had access to the provider's training as well. Nurses said they had access to professional development to meet their registration requirements. One said, "I'm starting a palliative care course at the local hospital later this year. We make sure staff are trained to meet people's needs. Training is specific to the people living here."

The Langford and Kennett "Main KPI (key performance indicator used by organisations to evaluate how they meet their own targets and performance objectives) dated May 2018 showed that in February 2018 90% of staff had a one to one meeting with their line manager and 90% had an appraisal. A member of staff told us "I had an appraisal with [manager] where we set personal goals, [spoke] about performance and [I] made a suggestion to meet more often".

People's needs were assessed prior to moving to the service. The manager told us that before an admission people's needs were assessed. Where people's needs were complex there were staff meetings and risk assessments were completed to ensure the safety of the person. These assessments formed the basis of care plans. We saw documented information from commissioners was provided before an admission.

Most people were unable to eat and drink orally. Instead they received their nutrition via enteral feeding tubes (PEGs). PEG regimes were clearly documented within the care plans. People's weights were monitored and when required, advice was sought from nutritional nurses to adjust the regimes.

We spoke with catering staff on the way people, who were not supported through PEG, were supported to maintain a healthy diet. They told us staff consulted with people on their menu choices two days in advance. Catering staff also told us the staff made them aware of special diets such as soft meals (textured diets), people's preferences and special celebrations. Two people were served with textured diets and records listed their preferences for what they liked to eat and drink.

People had access to healthcare services and received support with their ongoing healthcare. Records showed people were reviewed by the physiotherapist, speech and language therapist and the dietician. However, staff did tell us that they felt people did not see the physiotherapist as much as they would like. One staff member said, "There isn't enough input from physiotherapists or occupational therapists. It's improved a bit, but it needs to be more." Another said, "[The provider] says everybody will have more physiotherapy, but it doesn't happen." However, one of the registered nurses said, "[The provider] feels

there is more we can offer people in the way of therapies. It's getting better." Relatives also told us about the lack of physiotherapy that was offered as part of people's care. One relative told us because of this their family member had restrictive movement in their limbs. The registered nurses and manager confirmed that people were having access from onsite physiotherapists. They said a physiotherapist was assigned to work with people and visits from the appointed physiotherapist had taken place. They said these visits had been taking place for two weeks.

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.

Consent to care was mostly sought in line with legislation and guidance. Although people's capacity to consent to some aspects of their care had been assessed, this did not apply to all aspects. For example, people's capacity to consent to a flu vaccination had been assessed. When they were unable to consent, records showed how best interest decisions had been reached. However, mental capacity assessments were not in place for other aspects of care, such as the use of lap belts,. We discussed this with one of the registered nurses who said they would rectify this with immediate effect.

Staff understood the principles of the Mental Capacity Act. They explained how they offered people choices. A member of staff told us some people made day to day decisions such as "what they want to wear or eat". This member of staff also explained that best interest decisions were made through the mental capacity assessments for people that lacked capacity. We heard staff ask one person if they wanted to go back to their bedroom on one occasion. On another occasion a member of staff was asking another person which film they would prefer to watch. One member of staff said, "I always hold up a choice of outfits for people and give them the option to pick."

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS applications for care and treatment at the home were detailed and completed by the manager or by the social workers before the admission to the home. DoLS applications were in progress and as yet the home had not received authorisation.

Good

Is the service caring?

Our findings

There were people living at the service with complex nursing needs and were not able to express to us their experiences of living at the service. Where people were able to speak to us they said the staff treated with kindness and compassion by the staff. One person said, "the staff are very nice and really helpful." Comments from relatives included "They settled her down very well. They are very caring. " The care here has been very good", "Absolutely, kind, considerate, dedicated", "This place is absolutely fantastic – one of the best in the country", "They are all nice people. Overall, I am very satisfied", "They are really good" and "The nurses are brilliant."

The manager told us how they ensured staff were caring towards people. The manager said new staff had an induction before starting work at the home. All staff were dignity champions (staff that believe passionately that being treated with dignity is a basic human right, not an optional extra). Staff attend training to maintain their skills and their performance was monitored.

The staff we spoke with knew why it was important for staff to be caring and compassionate towards people. A member of staff said, "we talk to people. I feel that [people recognise] my voice. I speak about their life and about me. I read the "all about me" [documents] in bedrooms I get to know about their personalities." Another member of staff said, "my goal every day is to come in and give the best possible care I can. I love the people I care for" and "I take massive pride in helping people to look and feel great."

We observed and heard many positive interactions. Staff demonstrated they knew people well and people living at the service appeared relaxed around staff. A member of staff told us how they ensured people were made to feel they mattered. This member of staff told us "the actions from staff confirm to people that they matter. Making people feel comfortable. People need to know we listen to them. We care about people and want the best for them."

Relatives told us that staff listened carefully to their views and suggestions, and implemented suggestions where feasible. One relative said, "I am always consulted on non-medical issues and informed of important events." Another relative said, "I am listened to all the time and the staff act very quickly."

People's rights were respected. Care plans gave staff guidance to ensure people's privacy was respected. One person told us the staff, "respect my privacy and always knock on my door. I make my own decisions but the staff would always help me if necessary." Relatives told us, "they thought that their loved ones were treated with dignity, and respect, and that their privacy was also respected." Staff said they knew how to maintain people's dignity. Comments included, "I always make sure people have their hair done the way they want" and "I always make sure people are in co-ordinated clothes for example." One said, "I always tell people what I'm doing and why. I keep people covered up during personal care; they don't want to be exposed and neither would I."

People's cultural and religious needs were fully respected. For example, the festivals of one person's religion were celebrated, and their dietary needs were met. This was confirmed to us by their relative. The care plan

for one person was specific that the local priest visited each week and that staff should respect the person's privacy during this time. Another person was non-practising, but details of their cultural preferences were documented. Staff we spoke with were aware of these.

Good

Is the service responsive?

Our findings

At the inspection dated 14, 15 and 20 June 2017 we found support plans and associated care records were not person centred. Some terminology used within people's records did not promote a person-centred approach. We found a breach of Regulation 9 of the Health and Social Care Act Regulations 2014. Following this inspection, the provider wrote to tell us the actions that was to be taken to meet the requirements of the legislation. The action plan stated the actions to be met by 30 November 2017.

At this inspection we found care plans reflected people's health care needs. For example, tracheostomy care plans and plans about people's postural management needs were comprehensive and provided clear guidance for staff on how to support people. For some people their personal histories had been recorded or their individual preferences were part of their care plan. A registered nurse said "personal profiles are more about the person as an individual and takes the medical element away. It relates more to people and you [staff] see them as they were. I want [personal profiles] to be done by the keyworker that know the person over a period of time. "

Although one of the plans we looked at detailed exactly how the person wanted staff to support them during personal care for example, others did not. People's preferences in relation to what time they liked to get up and go to bed had not always been recorded. People's clothing choices and whether the females wanted to wear makeup or jewellery was not included. People's night time plans did not detail if they liked a bedside light on, or a window open.

Some people at the service were not able to express verbally their needs and preferences whilst care plans were written in the first person to portray people's voice. We discussed with the manager and registered nurses that a medical model was indicated. For example, people were known as patients and senior staff were known as ward sisters. We discussed person centred care planning with staff during the inspection and showed them the comparison between the one example of a very personalised plan.

Despite the lack of detail in plans staff did demonstrate they knew people well and were aware of their preferences. For example, one member of staff said, "I know [person's name] likes to look nice and to feel nice." Another said, "Families are the biggest source of information. I always ask families what things people liked before they came here." One said, "I know the toiletries [person's name] prefers to use. They've got loads of perfume they like to wear too." The agency worker said, "I know [person's name] likes to listen to music, so I will listen with them." However, some relatives did not give us positive feedback about agency staff. They confirmed that these shortcomings were the product of inexperience and unfamiliarity with the people and not the result of an uncaring attitude.

There were treatment escalation plans in place. These detailed people's choices about what kind of treatment they wanted if their condition deteriorated. However, there were no advanced plans in place in the care records we reviewed. These are plans which describe people's choices and any special wishes about their end of life care.

The staff told us that at handovers they were told about people's current needs. They said there was a rehabilitation assistant's handover sheet of allocated tasks. Staff told us care plans were devised by the registered nurses and where there had been updates staff were expected to read them. Some staff told us care plans were used for reference to ensure people's needs were met. .

The activity programme at this service was an area of strength. The home had a full-time activities coordinator. We observed the activities coordinator giving one-on-one attention in activities designed to mentally stimulate and amuse. The co-ordinator told us that time was invested in talking to relatives to understand the interests, and hobbies, of their loved ones. This meant people-centred activities were provided.

Each person had a day of one to one activity involving a day out. For example, people were supported on trips to concerts; horse racing; boating trips; wildlife reserves; the seaside and museums. Where feasible some people accompanied by staff spent a weekend with family members or their previous permanent home. The activities co-ordinator told us that, in one week eight people went on a community trip. This meant 50% of people had a one to one experience in the community. We saw that staff had decorated the lounge area with England flags and staff told us they had organised a party to celebrate England's success at the football World Cup. During the inspection we observed group activities of crafts and gardening activities.

The complaints procedure was on display which explains the process very clearly. Where complaints were made action was taken by the provider to resolve concerns. Two relatives told us they had raised concerns following injury to their family members. Both relatives confirmed that their complaints had been treated seriously and fairly. One relative said his complaint had been dealt with in an "excellent" manner. However, one relative commented that the process had been slow.

Requires Improvement

Is the service well-led?

Our findings

At the inspection dated 14, 15 and 20 July 2017, we rated Well Led as Requires Improvement. We found that while auditing system were in place for some areas, the shortfalls highlighted during the inspection were not identified by governance arrangements

At this inspection we found governance arrangements included quality assurance and some auditing systems. The Quality and Patient Safety lead emailed us and stated: "audits that are required to be undertaken are decided based on a number of different factors. For example, meds [medicine] management and documentation." They said this was because they "carry an inherent risk" The audits based on specific areas of catheter care, enteral feeding tubes and slings for hoists were 100% met. However, we found that auditing systems were not robust as all areas of care and treatment provided. For example, medicines systems, risk assessments and care planning.

We were provided with copies of the key performance indicators used to assess set objectives. The May 2018 results had identified that Medicine Management in Kennet was compliant and in Langford non-compliant, on "minor errors". However, we found for one person errors were made by the supplying pharmacist which had placed them at risk of harm. For another person the registered nurses had not administered medicines because there were no instructions on whether to crush medicines. For another person medicines were not available. The manager told us the supplying pharmacist carried out visits 12 months after the start of the contract. A meeting with supplying pharmacist was to take place where issues of concern were to be raised. We found that while there were systems in place to monitor some medicine systems the shortfalls identified for improvement was not acted upon in a timely manner.

Audits for infection control were not in place. The Quality and Patient Lead told us "we know the issues and therefore no need to have an audit. We talk it through at senior meetings". The minutes of the managers meeting held in May 2018 listed that there were "several issues and we are aware about them". The minutes also stated the site service manager was "aware of them" and how [housekeeping] staff shortages were to be addressed. However, the provider could not be certain that set objectives were being met.

Regulation 12 requires providers to prevent and control the spread of infection. The Department of Health issued The Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance, a Code of Practice about the prevention and control of healthcare associated infections which CQC must take into account when making decisions. In section 1.5 of the Code under Assurance framework states "Activities to demonstrate that infection prevention and control are an integral part of quality assurance should include an audit programme to ensure that appropriate policies have been developed and implemented". Section 1.7 also states "The infection and prevention and control programme should set objectives that meet the needs of the organisation and ensure the safety of service users. This meant the provider could not be certain of the progress made with meeting set standards.

Systems and processes did not clarify how risks relating people's health safety and welfare was monitored

and mitigated. The clinical lead told us there were "risk rounding" meetings where people at greatest risk were discussed. We saw risk assessments had placed some people at low risk although other documentation had placed them at high risk. For example, one person was identified at high risk because of their medical condition but the risk assessment score had placed them at low risk. A registered nurse said, "everything we do for [person's name] is high risk." When we discussed the risk assessment form with The Quality and Patient Safety Lead they said: "risk assessments forms have been used for years. There were minor changes [to the forms] as issues have arisen. This meant systems that audit the quality of service delivery were not continually evaluated to assess their effectiveness.

The "local improvement plan" devised by senior managers detailed areas for improvement, the progress being made and the status. We noted that all areas assessed were met. For example, care plans were not person centred on 22 Sept 2017 and staff were to develop "ME" documents. In October (year not specified) this area was met. Medication care plans and PRN were identified for improvement and on 20 May 2018 .2018 the "ward sister" had recorded "all care plans are person centred and rewritten". We found that actions identified as met in the improvement plan were not met for some people.

Accident and incidents were documented by the staff. The manager told us there was an online system for reporting accidents and incidents. The Langford and Kennet KPI for May 2018 showed there was one unplanned hospital admission and four medicine errors were reported to the Local authority safeguarding team. While staff safeguarding referrals were made CQC were not informed about these events. This meant the manager had not notified CQC of incidents notifiable under Regulation 18. The manager reported to CQC in retrospect all incidents that affect the health, safety and welfare of people who use services.

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

The staff we spoke with were aware of the values of organisation and how their roles and responsibilities supported these principles. A member of staff said the values included "communication and caring. We are knowledgeable, we are very caring staff. We communicate with people and families. We stay up to date on what is going on. We treat them [people] like extended families." The manager told us the values of the organisation included "dignity, safety and teamwork." The manager said procedures, monitoring staff performance and management presence provided the framework for staff to practice these values daily.

Some staff said they did not feel valued. Staff said morale was "variable" and "like a roller coaster." One staff member said, "We have our highs and lows but we try and lift each other back up." The majority of staff said they felt valued by their colleagues, but not by the provider. Comments included, "I feel like a tiny cog in a big wheel. They [senior managers] make promises but don't keep them" and "I don't feel at all valued by the company, not at all. The registered nurses always thank us, but not the management." However, one other member of staff contradicted this statement and said , "I think the management team are very approachable."

The manager in post was in the process of becoming registered with CQC. The manager said, "I am available at all times. I have allocated days in each unit." Ward sisters work in each unit and had day to day management control on the days when the manager was not in the unit. Staff spoke highly of their roles. Comments included, "As a team, I know we provide really good care." One of the ward sisters said, "I am 100% confident in the care staff. They're really good and work very hard."

One relative told us annual surveys and suggestions boxes were available for feedback and suggestions. The feedback from relatives about the service was variable about the communication between them and the

staff. Other comments made by relatives included "fairly well managed and nothing at Glenside concerns me. Staff are always approachable, and answer my questions as best they can."

The manager told us the systems in place for staff to receive constructive feedback and to share information. The manager said there were weekly and monthly ward sister meetings, monthly senior rehabilitation meetings. There were daily handovers from the ward sister at the end of their shift to the ward sister coming on duty which related to medical care. Rehabilitation assistants (RA) also had a handover when they arrived on duty from RA at the end of their shift.

The manager told us how learning from accidents and incident were used to make improvements and manage future performance. The manager told us the lessons were learnt from accidents which they investigated. Following from the investigation staff meetings took place to discuss actions and implement safety measures.

The manager told us how improvements and sustainability was to be addressed. The manager told us improvements had already begun with community activities and the cleaning regimes. Lead roles were to be assigned to people with specific area of interest. This meant that staff had a point of contact for information on specific areas. For example, tissue viability and safeguarding.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicine systems were not safe. We found gaps in the recording of medicine administered. There were errors with the medicines dispensed and some were out of stock. There was a lack of clear guidance on administering "when required" medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance and audit systems were not robust and did not cover all areas of care delivery.