Glenside Manor Healthcare Services Limited

Langford/Kennet

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:
Langford and Kennet are two eight bedded units that are managed as one service and provide complex nursing care for people with neuro degenerative or previous brain injury.

Langford and Kennet are 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. Some of the systems are managed centrally for all services; 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, also facilities such as the hydrotherapy pool are shared by people in all services.
One adult social care location (Pembroke Lodge) is currently closed as there were ongoing issues with the provision of heating and hot water.

The hospital is also currently closed due to flooding, caused by a major water leak. People from the hospital were transferred at short notice to some of the adult social care (ASC) locations. Works to repair the fabric of the hospital building are currently underway. As Langford and Kennet were temporarily accommodating people from the hospital we reviewed aspects of these peoples care and support in line with the expectations of their inpatient status. The Langford area is being used to accommodate people under the ASC registration and the Kennet area for those people previously accommodated in the hospital

The provider notified us of the temporary arrangements for hospital patients while refurbishments take place. However, Langford and Kennet 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.

At this inspection we found that people were placed at risk due to management shortfalls. We found systemic overarching poor management systems and that the required improvements were not prioritised. There had been sudden and continuing persistent changes of senior management. There was a lack of regulatory response from the provider. There were issues with poor recruitment procedures, and a lack of investment in 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.

People's experience of using this service:

The service was rated Requires Improvement at the comprehensive inspection dated July 2018. The rating for the focussed inspection undertaken on the 7 November 2019 remained the same.

For people receiving adult social care we found:

• Staffing levels had improved since the last inspection.
• Information about pain management was not always clear.
• Three out of eight people living at Langford had a history of epilepsy seizures, however, epilepsy management training was non-compulsory.
• Environmental risk assessments relating to fire safety, infection control, maintenance or temperature check were out-of-date.
• There were no logs of maintenance work requested by staff or carried out in the service. We saw there were areas requiring urgent maintenance and potentially posing a threat to people's health and safety.
• When agency staff were used, the service did not always ensure they were qualified and knowledgeable enough to lead a shift.
• The unit manager was not supported by the provider to ensure they could focus on making improvements. This included an ineffective maintenance function, and not having recruitment support from a human resources team.
• The service did not have a registered manager in post. The service was being managed by an interim manager.

For the hospital patients we found:
• 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.

• The maintenance of facilities and premises did not keep people safe.

• The clinical care for the people who were hospital patients was not safe. Staff were not able to identify and respond appropriately to changing risks to people who use services. National Early Warning Scores (NEWS) was not in use.

• There were not comprehensive risk assessments carried out 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.

• Nursing assessments and documentation were not in keeping with standards for nursing. 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.

• Medicines were overall safely managed.

• 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.

Whilst we saw that some improvements had been made these were not sufficient and additional areas of concern were identified. As a result the rating from this inspection is now inadequate .

Rating at last inspection: This service was rated Requires Improvement at the comprehensive inspection published on 30 August 2018.

Why we inspected:
This inspection was brought forward due to information of risk or concern. Since the inspection visit in October 2018 we received ongoing 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. These have not been received We also issued four warning notices following the focus inspection at Glenside Hospital in November 2018.

Follow up:
This service is now rated as Inadequate and placed on 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 and the rating of inadequate is repeated for any key question or overall, we will take action in line with our enforcement procedures. This will be to begin the process of preventing the provider from operating this service. This process will lead to cancelling the provider's 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, urgent enforcement action will be escalated. Where necessary, another inspection will be conducted within the next 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.

Langford/Kennet

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 Langford and Kennett was completed by one inspector for the people accommodated under the service ASC registration and one hospital inspector for those people who were inpatients. A team of inspectors inspected the other locations which are situated on the same site.

Service and service type:
Langford and Kennet are a care home for 16 adults and provides complex nursing care for those with neuro degenerative or previous brain injury. 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 did not have a manager registered with the Care Quality Commission. A registered manager 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 for registration with CQC, to become the registered manager.

Notice of inspection:
The inspection took place on the 13 March 2019 and was unannounced. At the time of the inspection there were 15 people and one hospital patient accommodated.

What we did:
During the inspection we spoke with two people, one relative and one member of staff. We looked at

information relating to people's care, including three care files, and records from visits with health and social care professionals. We looked at information relating to staffing, such as handover records, meeting minutes, rota's, training records and agency staff profiles. We also reviewed information regarding the management of the service. This included accident and incident records, the quality improvement plan, checks of equipment, fire safety checks, complaints records.

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 comprehensive inspection dated July 2018. At the focussed inspection dated 7 November 2019 we found evidence of a repeated breach of Regulation 12. At this inspection there were insufficient improvements to show compliance to the regulatory requirements, as well as evidence of further breaches of this Regulation.

For people supported under the adult social care registration

Assessing risk, safety monitoring and management

● Emergency procedures for keeping people, staff and others safe were in place but there was some information missing or out-of-date. Review processes were not identifying or implementing action to be taken to address these shortfalls. Personal emergency evacuation plans (PEEPs) were up-to-date and located at the entrance to the building in a grab folder so emergency services had easy access to them if needed. However, the grab folder did not contain any information about people's specific health needs, for example their allergies to certain types of medicines. A member of staff told us, "This could be improved. There is no hospital passport, no sheet we can give to hospital with a list of allergies". This means that in case of an emergency information about specific heath needs could be lost and people's needs might not be met effectively.

● Environmental risk assessments relating to fire safety, infection control, maintenance or temperature checks were out-of-date. Although all staff were required to read and sign the environmental risk assessment, only one member of staff signed to confirm that they had read the assessments, and this was in October 2017. This meant that assurances to check the staff knowledgeable of current environmental risks to the service were not maintained.

●There was only one trained fire warden in the service. No night staff or agency staff were trained as fire wardens.

● We saw there were areas requiring urgent maintenance and potentially posing a threat to people's health and safety. For example, there was a ceiling light hanging down loosely in the corridor as two out four screws were missing. A member of staff told us, "The [person's] bed shakes and vibrates when you are bringing this up. The bed remotes are taped up as there were wires hanging out. A light is hanging out in the communal area and one recliner chair's broken. We reported everything a long time ago, but no one seems to care". The system for reporting maintenance issues was not robust. There were no logs of maintenance work requested by staff or carried out in the service. Following our previous inspections, we are not assured that maintenance staff had the skills and competencies to fulfil their role, due to a lack of training and

English language skills.

● People who were at risk of developing pressure ulcers had pressure relief equipment in place. Most pressure relieving equipment was being used correctly and no one who had been identified as at risk had developed a pressure sore. However, one air mattress setting did not match the setting recommended by a tissue viability nurse. This meant this person was not protected from developing tissue breakdown.

● Information about pain management was not always clear. For example, one person was unable to communicate either verbally or non-verbally. The person's care files instructed staff to check on the person and to recognise if the person was in pain or discomfort. However, the same care file stated that the person was unable to express pain and did not provide any information on what potential signs of discomfort would be. We asked a member of staff if they knew how to recognise if the person was in pain. The member of staff told us, "I would not know when to administer painkiller. I have never noticed if she was in pain".

● Three out of eight people living at Langford had a history of epileptic seizures; however, epilepsy management training was non-compulsory. A member of staff told us, "I do not think it is safe. I had all the essential training but there isn't really something compulsory like epilepsy seizure management training. [Person] can have seizures, [another person] can have them more often and also [another person] may have a seizure. And epilepsy training is still non-compulsory". We looked at the training matrix provided to us by the acting manager and saw that no member of staff received training in epilepsy seizure management.

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.

Staffing and recruitment
● When agency staff were used, the service did not always ensure they were qualified and knowledgeable enough to lead a shift. We looked at the agency staff portfolios containing information about agency staff training and competencies. We found that some of the portfolios were incomplete or missing. We looked at nursing and rehabilitation assistant induction folders which were also required to be completed by agency staff, however, all the induction folders were blank inside. Some parts of the induction folder were required to be completed within 6 weeks of commencing the work for the service, however, they remained blank even when the starting date was in May 2018. The feedback from staff about the induction they had received was mixed.

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.

● There had been improvement in the staffing levels on Langford and the use of agency staff had been reduced. People and their relatives we spoke with were confident there were enough staff employed to meet people's needs. One person told us, "There are no issues with the staffing levels. They are always here when I need them". One person's relative said, "There are enough of nurses and they take care about her".

Systems and processes to safeguard people from the risk of abuse.
● People and their relatives told us they felt safe at Langford. One person told us, "Oh yes, I feel very safe here". One person's relative pointed out, "I have no concerns about her safety. I think she is very well looked after. They communicate with me if something happens, I believe that the communication is very good, and she is quite happy living here".
● Staff were trained in safeguarding and knew what to do if they were concerned about the well-being of the

people using the service. A member of staff told us, "I would report any safeguarding issue to my manager".

Using medicines safely
● We found that medicines were mostly managed well. 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.

Preventing and controlling infection
● We saw care staff had completed training in infection control and food hygiene. Care staff were provided with protective equipment such as gloves and aprons.

Learning lessons when things go wrong
● Accidents and incidents had been documented in the IT system and we saw the service had taken action to support people where required. The acting manager analysed accidents and incidents for trends and patterns, which resulted in positive outcomes for people. For example, people were referred to GPs or a tissue viability nurse.

For people supported under the Hospital registration
Systems and processes to protect people from the risk of harm
• Staff did not follow systems and processes to identify and act on harm. Staff were trained in safeguarding and knew what to do if they were concerned about the well-being of the people using the service. A member of staff told us, "I would report any safeguarding issue to my manager."

Cleanliness, infection control and hygiene
• Safety systems were not implemented to protect patients effectively from infectious diseases or to maintain infection control and hygiene.

• There was no process, checklist, or audits completed relating to infection control. We spoke with two housekeeping staff 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 were cleaned last. There were no cleaning logs in place. The ward sister showed us a cleaning schedule. This was a list of areas to clean and did not show whether the cleaning had been undertaken.

• A bathroom on was used as storage space for at least six patient's wheelchairs. None of the wheelchairs had clean stickers on them and some looked visibly dirty and worn. Domestic staff would have been unable to access the bath taps to run the water as required (for legionella purposes).

• Standards of cleanliness and hygiene were not always maintained. Staff didn't always decontaminate their hands 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. which indicated a lack of understanding of the principles of barrier nursing.

• 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. The sluice had a notice saying it should be locked when not in use. However, we found it was open and cleaning products were stored on the work surface. The clinical

waste bin did not have a bin liner.

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.

• However, despite NEWS not being in use at Glenside, in one set of records we reviewed on Kennet and Langford, we found a photocopied NEWS chart which had been produced by a local hospital. This did not have the escalation process on the back of the chart, and staff were not able to explain why this chart was being used. When staff were asked about a high NEWS score (3 or above) they said they called the doctor. Also, the nurse did not know how often observations should have been performed and for how long. As some observations were recorded on the HDU chart, NEWS scores were not accurate. This meant a patient could deteriorate without any recognition

• Skin assessments for suspected pressure ulceration 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. Sores 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 sores 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 found one patient on should have had the pressure set at a 66 on their air mattress, but it was set at 90. We raised this with staff, but they did not know how to alter the pressure.

• The service did not ensure that staff understood the process for accessing resuscitation equipment. The service 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.

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.

• Patients individual care records, including clinical data, were not written and managed in a way that kept people safe. The inspector reviewed a set of notes in detail on Kennett. The observation charts were reviewed from 3 January 2019 to 2 March 2019. There were 23 sets of daily observations missing of which 19 were wrongly recorded on the high dependency form. This meant that nursing staff were not able to identify whether the patient had deteriorated.

• Within the nursing evaluation, nothing was recorded about the percutaneous endoscopic gastrostomy (PEG) (a tube passed into a patient's stomach through the abdominal wall to provide a means of feeding when oral intake is not adequate) feeding regime. The dietitian had prescribed a feeding regime for the patient. We reviewed 18 fluid balance charts from 14 November to 15 December 2018. All the fluid balance charts showed the patient did not receive his prescribed level of fluid intake of 2,700 mls. On two days, it was documented the patient received less than a litre of fluid and feed. On one day 100 ml of fluid was documented as given. Fluid balance charts were not added up for either intake or urine output.

• Some fluids were recorded on the HDU chart from 2 December to 9 December 2018. According to these recordings, the patient received in excess of their prescribed amount of fluid on three occasions. Only three balances had been added correctly, three had not been added up at all and two were incorrect. From the documentation, we could not be assured the patient received adequate levels of nutrition and fluids.

• 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.

• Most records were incorrectly filed, some charts were missing, there was a duplication of recordings but in the wrong place. Paperwork for a patient being discharged that day was not in any order, vital signs were not recorded in a way that allowed trends to be identified, for example, temperature and pulse were written in. The charts were not clear. 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. These dates were before this inspection.

• 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. 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.

• Patients individual care records did not ensure their care was delivered in a safe manner. 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 plethora 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 were.

• 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 people 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 medication. However, medicines were noted, where appropriate, could be administered through a percutaneous endoscopic gastrostomy tube.

• We found that medicines were mostly managed well. 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.

The above concerns in all areas, 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 inspection dated July 2018. At the focus inspection dated November 2019 we took enforcement action and imposed conditions on the registration of the provider which related to Regulation 17 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 to us from February2019. 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 have 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 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 manager listed as 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 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 action 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 focus 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 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 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 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. Staff were concerned that the hospital (which was closed due to a flood) would not re-open and their jobs would be at risk.

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.

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

• During this inspection we found some improvements had been made to the governance processes and the new acting manager had established improved ways of monitoring staff performance and the care delivered. However, some of these improvements and changes were still in their early stages and needed to be sustained over a period of time to ensure people can receive consistent care. We saw that the running of the service had improved in the areas which were delegated to the acting manager but previously had been dealt on the provider's level.

• Staff, people and their relatives told us there had been a noted improvement and people's outcomes had also improved. Staff praised the acting manager for visible improvements in the running of the service. One person told us, "I think this is really well managed". A member of staff said, "I think she is great but absolutely mental doing this. She has come in to such a mess and she is sorting things out. She is here even at the time we go home. I find her very supportive".

• Some records were not always available, accurate or complete. Records such as agency staff portfolios or the legionella risk assessment and water checks were not available to us on the day of the inspection. Other records, such as daily hoist batteries daily maintenance checklist, had gaps.

• One person's 'consent to share information' form was signed by a member of staff as the person lacked capacity to do so. However, there was no evidence of a best interest meeting having been organised for the person regarding this decision.

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 were failures 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.

The enforcement action we took:

There were failures 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

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 were failures 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.

The enforcement action we took:

There were failures 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.