The Riverside Group Limited

Weetslade Court

Inspection report

Weetslade Court
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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 9 August 2016 and we returned on 10 August 2016 to complete the process. We previously inspected the service on 11 August 2015 and found that improvements were required as breaches of legal requirements were identified. After the inspection the provider wrote to us to tell us what action they planned to take with regards to staffing levels, person-centred care and good governance. At this inspection we found some improvements had been made in respect of staffing levels and person-centred care. Improvements were still required with the governance of the service.

Weetslade Court is an extra care service with 51 apartments contained in a complex. There is an office base and care staff provide people with a range of services including; personal care, medicines management, shopping, domestic and enabling services. Not everyone who lived there received care services from the provider and not all of the services delivered were regulated by the CQC. At the time of our inspection 50 older people lived at Weetslade Court and 44 of them received personal care and support from the provider.

There was no registered manager in post as the previous one had recently resigned. 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.

People we spoke with told us they felt safe living at Weetslade Court. Staff were trained in the safeguarding of vulnerable adults and they were able to describe to us their responsibilities with regards to protecting people from harm and abuse. Policies, procedures and systems were in place to support staff with the smooth running of the service. Care needs were assessed and work to ensure care plans were person-centred had started. Some risks to people were assessed. However, risk assessment documentation and information for staff on how to mitigate and control risks was either missing, inaccurate or the records were basic and brief. We discussed this with the national care service manager who agreed with our findings and told us development work in this area had been made a priority for the interim care manager.

There were mixed opinions amongst people and relatives as to whether there were enough staff employed at the service. The interim care manager told us they used agency staff most weeks to cover vacant shifts but had tried to use the same agency for consistency. Care staff told us they did not feel hurried in their duties and they were able to meet people's assessed needs. The national care service manager was in the process of recruiting more staff to strengthen their team of permanent care workers.

There was a medicines policy and procedure in place. A recent medicines audit had identified an increase in medicine errors. The interim care manager told us she had booked all of the care staff onto a medicine refresher training course. Other elements of medicine management required improvement, such as risk assessments.

Accidents and incidents were recorded, investigated and monitored. Action plans were in place to reduce the likelihood of a repeat event. The interim care manager reported all incidents to external bodies as necessary. Senior management analysed this information to track trends throughout the organisation.

Routine safety checks were carried out throughout the scheme by the provider's on-site housing support staff as well as by external professionals where necessary. Personal emergency evacuation plans had not been drafted for all of the people who required support.

Care staff told us they felt supported by the management team and had received regular supervision and appraisal. Staff meetings had not been held as often as planned, however, care staff told us they felt able to approach the interim manager and the national care service manager whenever necessary.

The management and care staff demonstrated an understanding of the Mental Capacity Act (MCA) and their responsibilities under this Act. The service assessed mental capacity and reviewed it as necessary. Care records showed that people had been involved in making some decisions, but more complex decisions that were made in their best interests' had been appropriately taken with other professionals and a relative involved.

We observed the care staff interacting with people over lunchtime. They displayed kind, caring and compassionate attitudes and people told us everyone was nice to them. We saw staff treated people with dignity and respect. We saw discreet interactions between care staff and people who required support to eat their meal. People and staff enjoyed a friendly relationship and knew each other well.

Improvements had been made and work was in progress to make support plans person-centred. We saw the service had introduced a 'Riverside Care and Support Plan' which included sections entitled, 'Who am I', 'Where I lived' and 'Things I enjoy'. One page profiles were also completed with essential information recorded at a glance. We reviewed five individual care records and found that not all of them were completed and accurate.

The provider promoted communal activities which were arranged by the housing support staff based at the scheme. We saw information on display about forthcoming activities and we observed people engaging in activities during the inspection which included an entertainer and games.

There was a complaints procedure in place. We reviewed eight complaints. Provider representatives had responded to these complaints in the absence of a registered manager. We reviewed response letters and saw evidence of internal investigations into the issues raised. Relatives told us they were not happy with the time it had taken to get a response and some were still not satisfied with the outcome.

The provider was monitoring the quality of the service. A provider representative had recently carried out a service audit which looked at aspects of the service such as accidents, incidents and complaints. The interim care manager was completing weekly medicine audits which we were able to review. The regional care services manager told us the interim manager had conducted an audit of care records however this had not been robust enough to identify the issues we raised during the inspection. We discussed this with the national care service manager who told us they would ensure a full review of the service was undertaken.

We have identified two 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 always safe.

Risk assessments were not always thorough and accurate. Not all risks to people had been assessed.

There had been an increase in medicine errors and records around medicines were not always accurate.

Recruitment was robust to ensure people were cared for by suitable staff.

Safeguarding procedures were in place and followed by the staff to ensure people's safety.

Is the service effective?

Good

The service was effective.

Staff were trained in key topics such as safeguarding, moving and handling and person-centred care.

Supervisions and appraisals had been carried out and staff told us they felt supported in their role.

Managers and staff worked within the principles of the Mental Capacity Act (2008).

Thorough and detailed information was handed between changing staff teams to ensure people's needs were met.

Is the service caring?

Good

The service was caring.

Staff displayed kind, caring and compassionate attitudes towards people. Staff knew people well.

People told us they found the staff to be friendly and respectful.

Staff understood their role with regards to maintaining people's dignity and privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Person-centred care planning had been introduced, however some records were missing, uncompleted or inaccurate.

Not all of the individual risks people faced had been recorded on assessments.

The responses to complaints had been unsatisfactory to some relatives. Several changes in management meant the complaints process was not followed through smoothly.

Is the service well-led?

Requires Improvement

The service was not well-led.

There was no registered manager in post. A succession of temporary managers meant some actions to make improvements to the service had not been fully progressed.

At regional and corporate level, plans were in place to address the issues at Weetslade Court.

Staff told us they enjoyed working at the service and were hopeful things would improve very soon.

Weetslade Court

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 9 and 10 August 2016 and was unannounced. The inspection was carried out by one adult social care inspector.

Before the inspection, the provider completed a Provider Information Return (PIR), which they completed and returned in a timely manner. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed other information we held about the service, including any notifications we had received from the provider about safeguarding incidents, serious injuries and other reportable events. We contacted the local authority commissioners and safeguarding teams for the service and the local Healthwatch. We used their comments to support the planning of our inspection.

We spoke with six people who used the service, one relative and one visitor. We also spoke with the interim care manager, the national care service manager , the housing administrator and five care assistants. We observed how staff interacted with people and looked at a range of records which included the care records for five people who used the service and three staff personnel files. We also looked at other documents related to the quality and safety management of the service.

After the visit to the location, we contacted a local authority care manager and another relative contacted us. Where people responded, we used their comments to inform our judgements.

Requires Improvement

Is the service safe?

Our findings

From the five individual care records which we examined we found the service had not considered all of the risks people may face. For example, two people who had a history of falls did not have a falls risk assessment in place. Other risk assessment documentation was basic and brief. For example, two people who required support with medicines which have 'special instructions' did not have sufficient details contained within a risk assessment to inform care staff of the risks, how to mitigate risk, control measures and what to do in the event of an incident. Some of the risk assessments we reviewed contained inaccurate information. For example two people were assessed as self-medicating. This meant they are capable of managing their own medicine without input from care staff. However, daily records completed by care staff showed that they were providing a verbal prompt to remind these two people to take their medicine. One person's medicine risk assessment referred to the person with the wrong name. One person's care file contained no risk assessment documentation at all. This meant the service had not assessed or mitigated all of the risks associated with the health and safety of people. We discussed these findings with the national care service manager who told us they would undertake a thorough review of all documentation.

The people we spoke with during the inspection told us they received support with their medicines at the time they expected it. However, relatives told us they had raised concerns with the management about repeated medicine errors. The interim care manager told us they had carried out a medicine audit recently and discovered an increase in medicine errors. People had not come to serious harm from these errors, however there was potential for a serious incident to occur. Care staff had followed the medicine errors procedure and sought medical advice where necessary. The errors had also been reported internally and externally as required. The interim care manager told us they had booked all staff onto a medicine refresher training course and they were continuing with weekly audits of the medicine records to monitor the management of medicines. Within the five care records we inspected, we looked at the Medicine Administration Records (MARs) for the people who required support with their medicines. These records were not satisfactorily maintained, for example signatures were missing and some entries were illegible. In addition, we noted from the recent internal audit that discrepancies had been highlighted with MARs such as missing signatures and stocks not checked. This meant we were unable to ascertain whether people had received their medicines in a safe manner.

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12, Safe care and treatment.

At our last inspection it was reported that the service had insufficient staffing levels and people's needs were not met in a safe, timely and consistent manner. This was a breach of Regulation 18, Staffing. It was noted that staff had been responding to a high volume of 'emergency' calls from people who were summoning the care staff for unplanned assistance. The management told us in the past 12 months they had carried out a lot of educational work with people around the use of the 'emergency cord' system. The previous high volumes of unplanned calls had significantly reduced as people were not summoning the care staff as much for non-emergency reasons. During the last inspection it was also reported that care staff rotas contained care visits which overlapped and there were no scheduled breaks for the care staff incorporated into them.

The provider has since implemented a new rostering system. This meant they were able to plan all of the care visits in advance and allocate each visit to a care worker. We reviewed the last four weeks rotas and found that no care visits overlapped, breaks were incorporated and time was built in for administration and training. Care staff told us they much preferred the new rotas and knew what shifts they would be working for months in advance. Care staff also told us they were rotated around the building to ensure they got to know all of the people who used the service well. One relative told us they did not like the inconsistency of different care staff visiting which the provider was aware of. There were several vacancies for care staff at the scheme which the provider was proactively recruiting for and the interim care manager was arranging agency staff to cover most weeks. They told us they tried to use the same agency to ensure some consistency with staff.

The provider had a business continuity plan which directed the management and care staff in the event of a major incident such as fire or flood. Arrangements were in place for the on-going delivery of care and support to people in such circumstances. Personal emergency evacuation plans (PEEPs) had been created for people and they informed the care staff and the emergency services of what level of support people required to evacuate the premises and how to do it safely. One of the five care records we reviewed did not contain a PEEP. We informed the national care service manager of this. Housing support staff carried out routine checks on the safety of the premises such as a weekly fire alarm test and periodic practice evacuations.

The provider had a central HR function which managed the administration of the recruitment. We were unable to check the personnel records of staff ourselves; however, the interim care manager told us that checks were carried out with the Disclosure and Barring Service (DBS) and two references were sought. The DBS check a list of people who are barred from working with vulnerable people; employers obtain this data to ensure candidates are suitable for the role for which they are to be employed. We asked the HR function to confirm the checks had been completed for the staff whose records we inspected, which they did. Care staff told us they had completed an application form and attended an interview. Care staff confirmed checks with DBS and references had been obtained prior to them commencing employment. The three care staff records we examined contained evidence of an induction process, training, and on-going development. This demonstrated that the provider recruited suitable people with a mix of skills, knowledge and experience to meet the needs of the people who used the service.

We reviewed the provider's disciplinary policy and procedure. We saw in care staff records that when care staff had fallen below the expected standards the management had met with them to discuss the issues. We reviewed a professional improvement plan which had been drafted for one previous employee. It contained objectives, tasks and actions as well as comprehensive support on how to achieve these and a target date for completion. We saw care staff had been monitored quite closely in recent weeks; performance and conduct issues such as high absence levels and punctuality had been challenged with those who continued to fall below the expected standards. This showed that the provider continually monitored the suitability of staff to work with vulnerable people.

People told us they felt safe living at Weetslade Court. They made comments such as, "I feel safe", "I love it here", "I'm alright" and "I love the place". A relative said, "Our Mum does feel generally safe" and "The best thing about Weetslade for mum is the secure yet independent form of living which is reassuring to mum and provides peace of mind for the family."

Safeguarding procedures were in place and staff demonstrated they understood their responsibilities towards protecting people from abuse. Staff had been trained in the safeguarding of vulnerable adults and attended regular refresher sessions. Safeguarding was a standard agenda item on the national 'Care Forum'

attended by senior managers from throughout the organisation. The national care service manager had recently organised a safeguarding event at the 'Care Forum' and the contents of the event had been shared with all staff. There was a safeguarding working group which consisted of leads in various topics such as religion and domestic violence. All of the people we spoke with had no concerns about their safety. The staff we spoke with told us they fully understood the policies and procedures and would have no hesitation in reporting any concerns they had to management. They also told us they had no concerns about the safety of people who used the service.

Good

Is the service effective?

Our findings

Staff received an induction upon commencing employment and completed a period of shadowing with an experienced member of staff. More recently new care staff had undertaken the 'Care Certificate'. The Care Certificate is a benchmark for induction of new staff. It assesses the fundamental skills, knowledge and behaviours that are required by people to provide safe, effective, compassionate care. This meant the provider had ensured new staff were supported, skilled and assessed as competent to carry out their role. Competency checks with existing staff had been carried out in the past, however these had not happened recently due to the changes in management. The service used internal and external training providers as well as external professionals and NHS staff to deliver specific awareness to care staff about individual's needs. Staff training needs were up to date, staff completed regular refresher courses through e-learning in key topics such as medicines, moving and handling and safeguarding. The care staff we spoke with confirmed their training was up to date, however most care staff told us they would prefer face to face practical manual handling refresher training instead of e-learning. We passed this information onto the national care service manager, who told us they would arrange this immediately.

Supervision and appraisal records were not as well maintained as they could have been. Staff told us they had attended one to one supervisions with a manager and that they had received an annual appraisal. Records of the annual appraisals were missing from all three files we reviewed, however, one member of staff was able to bring their copy in from home for us to review and the national care service manager showed us how the appraisals were recorded electronically. We saw the appraisal was a competency based assessment and it acknowledged hard work and commitment. The appraiser and a more senior manager had recorded 'thank you' comments. The staff member told us they made them feel valued and appreciated during an unsettled period and lots of change.

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. A small minority of people who used the service lacked the mental capacity to make particular decisions. Their relatives, the provider and external health and social care professionals had been involved in decisions made in their best interests. We saw evidence in staff records which showed staff had received training about the Mental Capacity Act and best interest's decision making.

We saw in care records that the service aimed to ask people to consent to the care and support they received. Three out of the five records we reviewed showed people (or relatives acting on their behalf) had given their written consent. We heard care staff verbally gaining consent before assisting someone with support. The care staff we spoke with told us they always knocked on people's doors and gained permission to enter. Some records showed consent had been gained for other aspects of the service such as photography and sharing information with external agencies.

One member of care staff told us there had been a recent team meeting where the management shared

information regarding company policies, the building and current issues. All of the care staff we spoke with told us a meeting was convened to introduce the interim care manager to them. However, regular care staff meetings had not taken place due to the absence of the registered manager and a succession of temporary managers. Despite this, care staff told us they had felt supported through the changes by the regional care services manager who they could contact easily by telephone or email. The regional care services manager showed us information they had shared with the care staff following a national safeguarding event and had produced a 'Care Forum Briefing' following a managers event, which provided staff with updates about management, safeguarding, other schemes and company policies.

A communication book was used between care staff to 'handover' information between each shift. We saw good evidence of thorough notes being communicated which were signed and dated by care staff as read. We cross referenced events logged in the communication book with people's daily records, and central management records and found issues, incidents and other events had been followed up and actioned. The staff we spoke with confirmed there was a handover briefing before they started each shift.

Staff supported people to maintain a good diet. We saw people were assisted by care staff to have their meal in the restaurant situated in a communal area of the scheme. The restaurant was operated by an external company and was not part of the provider organisation. It was clear from the laughter and chatter at lunchtime that mealtimes were relaxed and informal. We spoke with people following their lunch. One person told us, "If you don't like what is on offer, you can ask for something else". Another told us they weren't aware of any choice, they said, "The chef just makes a meal." One person told us the food was expensive and they only ate in the restaurant a couple of times a week. We observed some care staff had time to sit with people informally and chat over lunchtime. Care staff were discreet in their approach to people who required support to eat their meal.

Care records demonstrated the service had involved a range of external health and social care professionals when people's needs changed. We saw staff had made referrals to a GP, a Community Psychiatric Nurse (CPN), a behavioural specialist, wheelchair services and a chiropodist amongst others and they worked closely with people's care managers within the local authority. Records were made of their input and any communication. Progress, actions and outcomes were recorded.

The provider's organisation also managed the building and provided housing related support to people. The building was a purpose built extra care scheme which boosted beautiful, modern decoration, gardens and additional services such as a hairdressers, a beautician and communal activities. The design of the building was adapted to meet the needs of the people who lived there such as dementia friendly décor, adaptations to support safe mobility and a secure environment.

Good

Is the service caring?

Our findings

People spoke highly of the care staff. We heard comments such as, "They're all nice lasses", and "They're a canny [nice] bunch." Relatives confirmed staff were nice and friendly. It was obvious from the conversations we had, that staff knew people well. Some staff and people had been at the service since it opened almost three years ago and they enjoyed a strong, positive relationship. We sat with six people and one visitor and observed a lot of positive interactions between them and the staff on duty which contained a lot of humour and affection. All the staff we spoke with displayed caring and compassionate attitudes as they described people's care needs, their roles and responsibilities and the activities they sometimes got involved with.

Discussions with the management and care staff revealed that people who used the service did not have any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010; age, disability, gender, marital status, race, religion and sexual orientation. We saw no evidence to suggest that people who used the service were discriminated against and no one told us anything to contradict this.

Staff told us they had attended equality and diversity training and could describe the importance of treating people equally whilst acknowledging that everyone was different. Care staff were able to tell us about people's likes, dislikes and routines. One member of care staff told us, "We know people very well, everyone is different but we get to know their likes and dislikes from the care plan and through discussions." Care staff told us they were aware of different dietary requirements and allergies.
Care records showed where possible people, their relatives and friends had been involved in the care planning process. People had contributed to the information gathered in their support plan such as 'My average week', 'Things that are important to me' and 'Hobbies and preferences'.

We reviewed a 'Service User Guide' and an up to date 'Statement of Purpose' which the provider had produced and shared with people who used the service. These documents contained information about the company's vision and values. They explained what people can expect from the service and how it will be delivered. The provider produced a fortnightly newsletter called, 'What's on' for people to promote information about the service, the management and activities. Information on quality assurance, the complaints procedure and useful contacts were on display around the scheme. Leaflets containing advice and guidance on other relevant services were also available in communal areas.

Nobody who used the service at the time of our inspection required a formal advocate. In most instances a relative acted in this role and sometimes a member of staff did; however the national care service manager told us that they were aware of how to involve an independent mental capacity advocate from the local authority if they thought it was necessary. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions.

Care records which contained people's confidential information were kept locked away in the manager's office. The care staff we spoke with demonstrated the importance of maintaining confidentiality and privacy. We observed all staff treated people with dignity and respect throughout our inspection. Care staff records showed they had completed training courses in dignity and privacy. A relative told us, "Mum has

found staff to be very friendly, supportive and respectful". They added, "In terms of privacy and dignity, we have put a bell on the apartment door requesting staff call before entering as mum has expressed concerns that staff have just walked in."

The ethos of 'extra care' is to allow people to live independently in a safe and secure environment with support from on-site care staff. Staff supported people to maintain their independence and we observed people undertaking tasks for themselves. We saw care staff encouraged people and supported them only when necessary.

There was nobody receiving end of life care at the time of the inspection, however, the service had recently supported one person with this. The five care records we reviewed all contained blank 'end of life' care needs assessments. We discussed this with the national care service manager who told us they were aware of the need to "get better" at recording end of life wishes. They said staff did ask people about this aspect of care, but when people refused, this had not been explained or recorded on the paperwork.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found care records were not person-centred and they did not reflect individual preferences. This was a breach of Regulation 9, Person-centred Care. During this inspection we found significant improvements had been made in this area. New support plan documentation had been implemented. Staff had completed new care needs assessments and support plans with people which were person-centred. The records contained sections such as, 'Who I am', 'Where I lived', 'Things I enjoy' and 'Things that are important to me' as well as information on family, relationships, independence, hobbies, health, finances and work/learning. Four out of the five files we examined were thoroughly completed to a good standard with personalised details. One file did not contain this document.

One page profiles had also been drafted by staff to ensure care staff (or agency staff) could see 'at-a-glance' basic information about each person. The profile contained personal information, GP details, a health diagnosis and the person's routine. Two files did not contain this information.

We informed the regional care services manager about the missing documentation who told us they would ensure the documents were found or completed again.

The new documentation had been introduced in August 2015 following our last inspection. Staff had reviewed the documentation after six months and recorded any changes in people's needs. Other evidence of reviewing care needs such as local authority documentation was also present in some people's files. Care staff, relatives and local authority staff had been involved in this process.

People made their own decisions about which activities they took part in. Some people received an enabling service which allowed them to access the community with support from care staff. People could choose what they wanted to do in this time and we saw their preferences were recorded in support plans. One relative told us they had temporarily cancelled this service because they had not been asked about their preferences and they felt, "care staff had fitted it in when they could" and this was not a satisfactory arrangement. Feedback from the provider confirmed wherever possible customer's preferences of times were accommodated, however there were occasions where this was not feasible without detriment to others.

An extra care scheme consists of people who live independently in their own home as they would in the community albeit within the security of a scheme. However, the provider's housing support staff did arrange communal activities and we were told the provider had a small 'Tenant Participation Fund' to finance any arrangements. During the inspection we saw a singer arrived to entertain people in the communal lounge. The housing support officer told us there were weekly Tai Chi, and twice weekly bingo activities which were tenant-led. Other activities such as theatre productions, pantomimes and children singing carols at Christmas had occurred. People we spoke with told us they enjoyed the bingo and coffee mornings. We noted in customer feedback that there had been complaints about the lack of activities on offer. Providing activities was not an essential service offered by the provider although they did try to facilitate this. Any care staff involvement in communal activities was above commissioned support and beyond their role and we

saw care staff had participated in communal activities as best they could. We heard the housing support officer announce the start of an activity over the intercom to ensure everyone was aware of it.

There was a complaints policy and procedure in place and the people we spoke with told us they were aware of how to complain and felt confident to do so.

We reviewed eight complaints which had been made in the past 12 months regarding the quality of the service, medicine errors, lack of activities and inconsistent management. The records which were stored in a file in the manager's office were not well organised which meant office staff in the service were not aware of all of the issues and complaints and their outcomes. We spoke to the national care service manager about this who informed us that all the complaints were dealt with by a central complaints team and stored electronically, however the office staff at the service did not have access to this. We were able to view this system which we saw held the original complaints, letters of acknowledgement, details of investigation and outcome letters. The national care service manager had oversight of the complaints about this service and once they had been made aware of the complaints, they had delegated the investigations to other care managers within the organisation to investigate and respond to. There had been a delay in some complaints being acknowledged due to the absence of the registered manager, a succession of temporary managers and complaints not being logged appropriately upon receipt by office staff. This meant that although a system was established, complaints weren't always handled as efficiently as complainants had expected.

Relatives told us some complaints had not been responded to as well as they had expected and they felt this was due to the absence of a registered manager and to the succession of temporary managers. Two families we spoke with told us they were still not satisfied with the outcome of their complaints and had on-going issues which the provider was aware of and dealing with.

One relative told us, "Recent successive management changes at Weetslade has only confused and compounded the situation." Another relative told us, "I am waiting for a review with our [local authority] care manager. We said we would give them [the provider] 12 weeks and that time is nearly up." A local authority care manager informed us after the inspection, "I have had a number of conversations with management and a meeting and although we had agreed points these were not followed through." They added, "The difficulty has been the change of management/senior [team] and things not being following through with plans that had been agreed."

Although we heard lots of compliments during the inspection, we noted there were none recorded. We spoke with the national care service manager about this who told us they needed to improve in this area. They confirmed that any compliments received had been verbally passed onto the staff.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, a breach of Regulation 17 which related to good governance was identified. During this inspection, we found that sufficient improvements had not been made in this area.

One relative said, "To improve the service at Weetslade there is a need for continuity of management and care staff to ensure delivery of holistic services and care in compliance with Riverside [Group] defined protocols." Another relative told us, "To improve the service I would like to see stability of management, continuity of care and better communication."

The service did not have a registered manager in post. The previous registered manager had been absent from the service since April 2016 and had subsequently resigned from the organisation. There is a condition on the provider's registration with CQC to have a registered manager at this location. The national care service manager was in the process of recruiting a suitable person to this post. The provider had notified the CQC of the absence of a registered manager as they are legally obliged to do. The provider had appointed an interim care manager who was present during the inspection.

Although systems were in place to identify and mitigate risks we found the service had mainly considered risks around moving and handling, medicines and fire safety. The records which were made were not always accurate and completed. Specific individual risks which people may have faced had not been documented. For example, the risks from a behaviour which may challenge the staff had not been considered for one person whose care records we reviewed. Risks associated with people accessing the community, such as road safety and vulnerability had not been considered for three people whose records we reviewed. Two people who were at risk of falling did not have a falls risk assessment in place. The national care service manager told us that in the absence of the registered manager, the interim care manager had been tasked with completing a thorough review of risk assessments, however, due to the succession of temporary managers and the departure of office staff, other aspects of the service had taken priority. The review of risk assessments had not been thorough enough to identify the issues we raised during the inspection. Despite this, care staff were able to tell us about the risks people faced and how they implemented control measures. We noted there had been no significant impact to people due to the lack of risk assessment documentation.

Audits had been completed for some aspects of the service. We reviewed the weekly medicines audit and a finance audit regarding the expenditure of one person's personal money which had been completed by the interim care manager. Medicine audits had not been consistently carried out over the past few months but the interim care manager had restarted these. The finance audit had just been introduced by the interim care manager following an incident where procedures were not correctly followed by care staff.

This is a continuing breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17, good governance.

The housing support officer carried out an audit of accidents and incidents to monitor types, trends and

actions taken. This information was submitted with other statistics to the provider on a weekly basis to measure key performance indicators (KPI's). This demonstrated the provider had some oversight of the service.

No surveys had been carried out in the past year with regards to customer satisfaction. We saw a survey had been carried out in 2014, however responses were poor and feedback received at the time was that the surveys were too long and complicated. The national care service manager told us the provider intended to create a simplified version which would be given out to people at Weetslade Court in the near future. The survey was currently being trialled in other schemes. 'Complaint, Compliment or Comment' forms with a reply slip were available in the reception area for people, relatives or visitors to complete and return anonymously if they wished. One form had been recently received about the lack of activities.

The housing support officer had recently circulated a survey regarding the arrangements surrounding the choice of meals in the restaurant. People had been asked for their preferences with regards to how many choices they would like to have. There had been little response. Another survey had been circulated regarding the introduction of a regular coffee morning in conjunction with the Alzheimer's Society. Five responses out of 50 had been received.

The national care service manager showed us a publication which had been recently compiled by the provider's research support officer. Data had been collated from six schemes in the region (including Weetslade Court) and was analysed to gather an overall picture of the provider's performance in relation to the frequency of accidents, incidents, safeguarding reports and CQC notifications. This demonstrated the provider had some oversight of the service.

We were told that the provider's senior management team were developing an action plan for the next six months to address the issues at Weetslade Court. Peer support had been arranged to support the management at Weetslade Court. They were also about to undertake some work with a consultant around mapping their paperwork to CQC's 5 key questions (Is the service safe, effective, caring, responsive and well-led?). The provider's central quality and compliance team would lead this with input from managers around the country.

At corporate level, the provider held a 'Care Forum' where managers met to discuss development, share best practice initiatives and learning outcomes. A new corporate medicines audit was being created and the manager who had trialled it fed back their opinions at the care forum. At regional level, managers meetings were held to ensure managers had a network of support and to share knowledge and ideas.

The service worked in partnership with other organisations including the local authority. A representative from the local authority commissioning team confirmed that the national care service manager was working with them to improve the service following an inspection from their team. Another care provider delivered the evening service at Weeslade Court and the two organisations worked together to ensure there was a smooth hand over of information. The interim care manager met twice weekly with an agency to ensure continuity of the staff provided from them.

The provider ran a national award system for staff who 'go the extra mile'. One member of care staff told us they had been nominated by someone and won an 'outstanding contribution' award. They received an email from head office offering congratulations, a pin badge, a certificate and vouchers. They told us this made them feel appreciated in what had been a "rough year". Other staff benefits were available such as offers and discounts with high street retailers, however, not all of the staff were aware of this.

All of the staff we spoke with spoke positively about their job. We heard comments such as, "I really enjoy working here", "I'm happy working here" and "I love my job." They all acknowledged they had been through a lot of changes and were confident things would improve. One member of staff said, "Staff have coped well with the changes, we have pulled together as a team". Another said, "It's been challenging but I've stuck it out, hopefully things will improve." Two members of care staff told us morale had been low but it was picking up now.

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had failed to assess all of the risks to health and safety which people may face when receiving care and support. The service was not doing all that is reasonably practicable to mitigate such risks. The management of medicines was not safe. Regulation 12 (1) (2) (a)(b)(g)

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
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Although systems and processes were established, they were not operated effectively to ensure compliance with requirements. They did not enable the management to assess, monitor and improve the quality and safety of the service or to assess, monitor and mitigate risks relating to the health and safety of service users. Records were not always accurate, completed and contemporaneous. The service did not seek and act on feedback. Regulation 17 (1)(2)(a)(b)(c)(e)

The enforcement action we took:

We issued the provider with a warning notice.