Wemyss Lodge Limited

Wemyss Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this inspection over three days on the 1, 2 and 8 March 2017. The first day of the inspection was unannounced.

Wemyss Lodge is registered to accommodate and provide nursing care to up to 60 people. The accommodation is in single rooms with the exception of one double room. Wemyss Lodge has bedrooms on the ground and first floors. A passenger lift is available for people with mobility difficulties. There is a communal lounge and dining area on the ground floor with a central kitchen and laundry room. People are supported through individual care planning to meet a range of needs including living with dementia, physical disabilities and health conditions requiring nursing care and support. The home is located in a residential area of Swindon.

In March 2016, a comprehensive inspection identified the service was not meeting a number of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care was not consistently delivered in a safe and effective way and there were not always enough staff to effectively meet people's needs. In addition, quality auditing systems were not identifying shortfalls in the service. We issued three warning notices to the provider, as a result of the concerns we identified and the service was rated as inadequate. The service was placed into special measures. Special measures provides 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.

In October 2016, we completed a focussed inspection to ensure improvements had been made. We found the provider had taken the immediate action necessary to improve the service as required of the warning notices, however at this inspection we found some of the improvements had not been sustained and further shortfalls were identified. Insufficient improvement had been made to enable the service to come out of special measures.

Following the inspection in March 2017, the registered manager who was in post at the last inspection submitted an application to de-register. A new manager was recruited in November 2016. Both the current registered manager and the new manager were available throughout the inspection and the manager was in the process of registering with the Care Quality Commission, to become the registered manager.

During this inspection, improvements had been made to the service. The management of medicines had improved although there were still areas which required improvement. Where incidents had occurred the service were now including more detail in the incident forms in order to plan preventative care. Some risk assessments such as the 'Personal Evacuation Plans' did not contain sufficient guidance for staff on what support each person required and people who could not use their call bell had not been risk assessed to ensure they received timely and appropriate support.

People told us they felt safe living at Wemyss Lodge. Staff were confident when explaining what constituted

abuse and were aware of the procedures to follow if required. Medicines were not always being managed in a safe way.

There were sufficient staff available to meet people's needs. The numbers of staff required during the day and night had been reviewed and amendments made. Safe recruitment practices were followed to ensure new staff were suitable to work with vulnerable people.

People told us they liked the food and had enough to eat and drink. There were positive comments about the quality and variety of food. Staff gave people time and interacted in a friendly, caring and attentive manner. People's rights to privacy and dignity were maintained.

Improvements were required around the implementation of the Mental Capacity Act 2005 and how the care records underpinned the Act. People received the support of health and social care professionals and referrals were made.

Staff were receiving supervision and training, however not in line with the provider policies. No appraisals had taken place, however these had been planned for 2017.

There was a range of activities people could take part in and this service continued to be developed around people's specific needs. The home had undergone redecoration and was warm, welcoming with many sensory objects to illicit people's interests.

Staff were kind and caring in their approach and improvements had been made in how they addressed and spoke with people. There were some practices which were institutionalised in their approach, such as wiping each person's hands at the table.

Care records required improvement as they were not always person centred, lacked sufficient detail and information and records were not always accurate between the electronic system and the paper records.

Audits were taking place, however improvements were required to ensure that there was an overview of the audits required and checks that these audits were being completed within the timescale set by the provider.

The provider had sought the service of an external consultant who would continued to support the home with their auditing processes and development.

We found five breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 fully safe.

The administration of medicines were not managed in a safe way.

People told us they felt safe and liked living at Wemyss Lodge.

Incidents and accidents were being recorded with more detail.

Some risk assessments were not in place or did not contain sufficient guidance to staff.

Is the service effective?

Requires Improvement

The service was not fully effective.

Improvements had not been made to the how the home were implementing the Mental Capacity Act 2005.

People told us they had sufficient to eat and drink.

Staff had not received supervision and mandatory training in line with the provider policy.

The home and been redecorated in some areas and was warm and welcoming.

Is the service caring?

Good

The service was caring.

People told us the staff were kind and caring.

Staff were attentive to people's needs and spoke with people in a respectful manner.

The local hospice service praised the home for the support people received and found staff were caring and compassionate.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

Care records were not person centred, lack sufficient information and were inconsistent between the electronic and paper records.

People took part in a wide range of activities which they told us they enjoyed.

People and their relatives knew how to make a complaint and were confident any issue would be dealt with effectively.

Is the service well-led?

Requires Improvement

The service was not well led.

There was a lack of an overview of how the service was performing due to a lack of routine audits taking place.

Staff told us they felt well supported by the management team.

People's personal information was not always kept confidential.

Wemyss Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 was unannounced on the 1 March 2017 and continued on the 2 and 8 March 2017. The inspection was carried out by three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

In order to gain people's experiences of the service, we spoke with 16 people, seven relatives and two visiting health care professionals. Following the inspection, we also received feedback from three health and social care professionals. We spoke with the registered manager, the manager and eight staff. We looked at people's care records and documentation in relation to the management of the home. This included staff training and recruitment records and quality auditing processes. We looked around the premises and observed interactions between staff and people who used the service.

Requires Improvement

Is the service safe?

Our findings

During the comprehensive inspection in March 2016, we identified people's medicines were not being safely managed. We issued a warning notice to ensure the provider made improvements. During the focussed inspection in October 2016, we found immediate action had been taken to improve the medicine administration systems. During the inspection in March 2017, these improvements had not fully been sustained and some shortfalls were identified in other areas.

Medicine audits were inconsistent and not all areas of the medicine systems were assessed. Audits were completed weekly by the registered manager and monthly by the lead registered nurse in medicines. A member of staff said the medicine systems was improving and stated that the lead nurse no longer accepted medicines with "as directed" instructions. However, the weekly and monthly audits were inconsistent with each other. Issues identified with ordering medicines and recording the dates on topical creams were not part of the weekly audits. This was supported by the weekly audit dated 23 February 2017, where all standards assessed were met but the monthly audits had identified shortfalls. Also, an action plan had not been developed on how the shortfalls were to be met. This meant there was no clear overview of medicine systems and no plan for ensuring where shortfalls were identified action was to be taken to meet these standards.

Medicines were administered covertly [disguised] for some people and for others they were crushed for people with swallowing needs. A registered nurse told us one person was refusing to take their anti-convulsant medicines because they were not able to swallow the tablet. They said the advice was not to crush the medicine and there were issues with the GP prescribing the medicine in liquid form. It was stated the person was having seizures. This registered nurse stated they made every effort to ensure the person took the medicines. It was further stated, "We find the tablets in the bedroom they are not taking the medicines". The manager raised a safeguarding alert for this person and contacted the GP practice where it was agreed to prescribe the medicine in liquid form.

Members of staff had not sought advice about the best method of disguising medicines for all the people with covert administration of medicines. The pharmacist contacted the registered manager in writing on the 1 August 2016 stating some medicines were being crushed without their agreement. The Medicine Administration Record (MAR) for one person showed staff had been crushing their medicine although it was recorded the medicine was not suitable to be crushed.

One person was having their nutrition and medicines through a percutaneous endoscopic gastrostomy (PEG). The administration of nutrition was not recorded on the MAR charts although prescribed by the GP and there were inconsistencies between staff on the volume of nutrition to be administered. While a care plan was in place, the guidance from the Speech and Language Therapist (SaLT) was not available and staff did not take steps to ensure the information was available. The fluid intake was not administered according to the care plan and no action was taken to ensure adequate amounts of fluid were administered daily.

A record of thickeners used in fluid was not maintained and were not labelled on how staff were to use

them. Thickeners prescribed by the GP were kept in bedrooms and not in a secure lockable cabinet. People were having pureed and "double pureed" textured meals and there was no clear guidance on the texture of the meals and the foods that must be avoided. We were told the decision reached on serving textured meals was from the observation of people and the problems they had with swallowing.

Some people were prescribed with topical creams and ointments and for some they were kept in their bedrooms. Where topical creams and ointments were kept in the medicine cabinets they were administered by registered nurses and MAR charts were signed when applied. Topical creams and ointment kept in bedrooms were applied by members of staff. However, MAR charts were not always signed when topical creams and ointments were applied. The lead registered nurse in medicines said this was an area where staff were not following instructions. Topical creams and ointments were not part of the audits of medicine systems. This meant registered nurses could not be certain when topical creams and ointments were applied and who applied them.

Homely remedies were administered from a stock supply of medicines which the GP had agreed for staff to administer to their patients when required. These medicines included, pain relief, cough mixtures, indigestion and laxatives. The record kept for medicines administered included a brief summary of the procedure which stated the date, time and running balance must be recorded and on the reverse side of the MAR chart the reason for administering the medicines must be recorded. We looked at the MAR charts for one person and the record indicated the pain relief was out of stock However, on the reverse of the MAR chart the pain relief administered from the stock supply was not recorded. For another person the homely remedies records stated that on two occasions pain relief was administered. The MAR chart indicated the medicines were out of stock. Staff did not complete the reverse side of the MAR chart when pain relief was administered. This meant that staff may offer pain relief when the medicine was already administered. We drew this to the attention of the registered manager.

The manager told us they were changing the pharmacy which supplied medicines to the home. This would mean a more robust system as the pharmacy also supplied individual medicine cabinets which could be fixed to the wall in the person's room. Pharmacy stocks would go straight into the person's cabinet and thereby help to reduce the likelihood of errors.

At this inspection the manager told us that upon starting work at the home they had completed an assessment of incidents and accidents. They found the nursing staff had not informed the registered manager about five incidents involving people which had occurred, the outcome included bruising and skin tears. These incidents were not documented in an accident or incident form and they were not investigated. Subsequently people were placed at risk of not receiving appropriate care and support and timely intervention, care records were not updated as a result and people's safety was not monitored in light of the individual incidents. The manager told us they had now implemented a more robust communication system with the nursing staff around reporting all incidents.

For each person there was an evacuation risk assessment in place. The risk assessments determined if people would require support from staff during the evacuation. However, for some there was insufficient guidance for staff on what support was required. One person's assessment stated the person needed maximum support as they were unable to mobilise but there was no information on what this support was. Within this person's care plans the assistance required in October 2016 stated they needed carer guidance. In January 2017 however it stated 'Not applicable' to the person needing assistance. Further care plans then recorded this person needed 'Total support' which was not consistent with earlier assessments. However, we observed that this person stayed in bed and needed full support to mobilise with the aid of a hoist and two staff. Staff also told us three carers assisted when this person was taken in a wheelchair to the

bathroom.

For people who were confined to bed and could not use their call bell, there was evidence that hourly checks were taking place. However, staff could not be assured that people did not require assistance in between the hourly checks and a risk assessment to mitigate potential risks for each person was not in place. Following the inspection the manager informed us this had been completed with all relevant consent and paperwork in place.

There had been some improvements made to the Kitchen. The unit which housed the dish washer in the kitchen had been replaced. However, the linoleum in the kitchen had patches of repair which was a temporary measure to the concerns we previously raised about infection control and due to staining of the linoleum it was difficult to ascertain if the floor was clean. The manager told us the flooring was being replaced. The back door of the kitchen had tape fixed to the window surround and the netting on the door and instep were not clean.

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

In March 2016 we found that accidents and incidents were not being appropriately monitored with sufficient detail about the incident in order to mitigate further occurrences. We found more information about the incident or accident was being recorded to inform preventative planning. The manager had reviewed the timing of when falls were more likely to take place and had taken remedial action regarding staffing availability at this time.

We received many positive comments about how people felt living at Wemyss Lodge and their safety. Statements included "Coming here was a godsend. People care about you and help you"; "If I fell someone would pick me up. My alarm is always near at hand – they come quickly", "Yes I feel safe because there are lots of people around. Lots of staff around", "Yes, can't complain about the home itself". Nice and clean" and "They [the staff] check me in the night – I feel safe".

When we asked about the level of staffing in the home people told us they could always find or call a member of staff if they needed assistance. They said they usually did not have to wait too long before their call bell was answered. A relative told us "There are more staff now and they are more aware of what's going on".

Staff were visible during the inspection and seen to be attentive to people's needs. The manager had introduced a system of calculating staff numbers based upon people's changing needs and staffing levels were based on the hours required. This had been in place since January 2017 and records demonstrated staffing numbers were being monitored and adapted when required. Staff gave a mixed response to the question of staffing levels, with most saying they felt there were sufficient numbers and with some staff stating they considered they needed more staff to be able to spend quality time sitting and chatting with people.

Staff had received further training in safe manual handling practice and we observed staff safely supported people to reposition using a hoist and when moving people whilst in their wheelchair. Each person had an individual sling where required and hoists and moving equipment was checked for safety, wear and tear and continued suitability.

Chemicals and cleaning products which had previously been stored in the communal wet rooms had been

removed and safely stored away. People were not using shared toiletries and arrangements had been made to store people's individual toiletries. The home was clean throughout. People we spoke with said they were happy with the standards of cleanliness maintained.

Staff were aware of their responsibilities in safeguarding people and were able to describe what abuse was and what action they would take in order to keep people safe. Notifications around safeguarding people had been submitted to the commission as required.

Safe recruitment procedures were in place, to ensure people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people. All applicants provided evidence of their identity and were subject to a formal interview. The provider was adhering to their policy of the timescales they had set to review staff DBS status. The manager told us recent recruitment had worked well. They said they had recruited a number of skilled and experienced staff to join the team. The manager told us the new appointments, in addition to improving staffing numbers and consistency, had helped further develop the home. A newer addition was the recruitment of a deputy manager.

Environmental checks were completed such as weekly fire alarm tests although we noted during the inspection that people had not been informed of a fire alarm test which resulted in one person stating to us "turn off that racket now". Safety checks of the premises were completed as was testing of the water systems for legionella. Eight new wheelchairs had been purchased following audits which had identified that the previous wheelchairs were no longer suitable due to wear and tear.

Requires Improvement

Is the service effective?

Our findings

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

At the inspection carried out in March 2016, we found the provider had not adhered to the principles and processes of the Mental Health Act 2005. At this inspection we found little improvement had been made. The Mental Capacity Assessments we looked at had not been reviewed to ensure they were still appropriate, some had not been renewed, there was no evidence of people's involvement in the process or how the registered manager had tried to support the person to understand the decision being made.

Mental Capacity Assessments were not decision specific and demonstrated a lack of understanding in the best interest process. Best interest meetings were not being held which involved the person, their family and relevant others. Care records stated staff made decisions in the best interest of the person, without recourse to the process of a best interest meeting and a relevant decision maker. Consideration had not been given to a capacity assessment and subsequent Deprivation of Liberty Safeguards (DoLS) for the use of sensor mats and bed rails which could be restrictive, the use of covert medicine [without the person's knowledge] and freedom of movement, for example the doors leading to the garden were closed. This could be seen as depriving people of their freedom of movement and was not the least restrictive practice to keep people safe. People and families told us if they wanted to go into the garden they would have to find a member of staff who had the key to open the door.

Ninety-one percent of staff had received training in the Mental Capacity Act 2005 (MCA), however not all staff were confident in explaining their responsibility under the Act. We spoke with registered nurses and care staff, some who were not clear on the purpose of the MCA. One member of staff told us they were not aware of the MCA principles and they were going to request this training. They told us people were "able to make day to day decisions such as engaging in activities and leaving their bedroom, but things were done in people's best interest". The member of staff was not able to tell us what constituted a best interest decision.

The home held information regarding the lawful authority of families to make decisions on behalf of a loved one through a legal power of attorney (LPA), either for finances or health and welfare. However, the electronic care records did not correlate to the LPA records and families were making decisions without having the lawful authority to do so.

At the inspection in March 2016, we found that when people shared a bedroom their consent had not been sought in line with the Mental Capacity Act 2005 and no management plans were not in place of how the home would support people's privacy, especially in the event of a death. Following the inspection the

manager informed us they had addressed the concerns raised.

Wiltshire local authority carried out a quality audit of the home in January 2017 and found shortfalls in how the MCA and DoLS were being applied.

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

At a previous inspection in March 2016, we found staff were not receiving supervision or appraisals to support their practice and personal development. Mandatory training as set by the provider was not being completed within the timescale required of the provider. At this inspection there had been improvements. Records confirmed and the manager told us, that at least 70 percent of staff had completed recent supervision and the nursing team had taken part in a group clinical supervision. The supervision matrix evidenced that staff had received supervision in 2016 however were not yet receiving supervision every two months as required by the provider. No members of staff had undergone an appraisal to review the past year's performance and to plan staff development for the year ahead; however these were to take place in August 2017.

Likewise, the mandatory training as set by the provider was not being completed in line with the provider policy on the frequency of refresher training. The training matrix had been updated and now reflected a more accurate picture of the training staff had completed and training which had fallen behind. The matrix also highlighted where records were not in place. Some of the training courses which had been identified as requiring a refresher were for example, infection control, fire safety, manual handling and MUST training. Dates had been booked in for training to take place.

Staff undertook training in de-escalation. This is where staff would use techniques to deflect a potential conflict resulting from a person's behaviour. However, staff had not completed training in supporting people with behaviour which may challenge in order to understand the behaviour and identify potential causes before needing to de-escalate. The manager told us they would be sourcing this training.

Wiltshire local authority had carried out a quality audit at the home during January 2017 and found shortfalls in staff supervision, appraisals and training.

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

The dining experience for people had seen many improvements. There was a clear procedure for staff to be able to discreetly collect the meals from the dining room to be delivered to people in their room. This resulted in a calmer and more relaxed environment in the dining room. Staff had a list of all people who received meals in their room; this included what they had chosen to eat and specified any special dietary requirements and whether the person required support.

Dining tables were set up with cutlery, condiments and napkins and a written menu was on each table. We were shown an example of a pictorial menu which had been designed for the breakfast selection, however the picture was too small for people with visual impairment to be able to see clearly. Staff and the manager confirmed they were currently designing the picture menus and these would be available shortly.

People were asked by staff where they would like to eat their meal. We observed staff supporting people with their meal in their room and this was carried out in a calm, caring unrushed way. Staff chatted to

people about day to day topics as well as describing the food they were being given. People were checked on to see if they were eating their lunch. We observed one resident being asked whether he wanted his lunch kept warm as he was sleepy, he said yes and this was done immediately.

For people who chose to eat in the dining room, we found for the most part people were supported to eat and drink with staff offering to cut up the meal into bite sized pieces if required. However, we observed one person who was sat at the dining table and had not been given a drink. Two members of staff were close by but did not notice the person drink the vinegar and then the brown sauce. We intervened at this point and asked the member of staff to give the person a drink. The nearest member of staff told us they were concentrating on supporting the person they were with and had not noticed the incident. We fed this information back to the manager who told us they would review this with the relevant members of staff.

For the most part, staff supported people to make choices by showing them the lunch plate and giving an explanation of what the food was. However, this approach was not consistently done by all staff when taking people's meal preference. Some staff held the plate at too higher level for the person to see and did not explain the food, rather explaining "we have a stew and fish pie", but not what type of stew or fish it was. Similarly, most of the staff asked people if they wanted to wear a clothes protector and gained their permission before placing it on the person. There were staff who did not do this and placed a clothes protector on the person without an explanation or consent.

We saw fresh vegetables were used to prepare meals; the meals looked appetising and nutritious. The chef told us most food was prepared at the home. They also told us the menus were to be updated with the changing season. Casseroles, fish pie and pasta had been added to the menus at people's request. Catering staff were provided with nutritional assessment forms which told them about people's likes, dislikes, assistance needed and special instructions. Also included was the location of where people preferred to eat their meals.

The nutritional assessments showed 13 people had pureed or soft textured meals and two people had their meals "double pureed". When we asked the catering staff about the guidance provided on serving textured meals they told us they were "Present during Speech and Language Therapist (SaLT) visit".

People could select from a choice of cakes, pastries and desserts from a cold storage display and staff told us these desserts were available during the day including when afternoon tea was served. The tables in the dining room were arranged in one long table which did not fully promote social interaction. However, the manager told us they were awaiting delivery of round tables which would enable the dining experience to be more sociable.

People told us they had enough to eat and drink. The majority of people told us the food was good and they had a wide range of food to choose from. People told us "The food is very good. I have a glass of sherry. The dining room is very well laid out and immaculate", "Good. Plenty of food. Good choice. I choose when I go to the dining room", "The food is super. I like plain food and you get a good choice" and "Not cooked properly, too much salt and very hard. Not cooked well enough".

To encourage people to drink there were two juice stations which supplied different flavoured fortified drinks. Water was also readily available at dispensers. We saw that people had access to jugs of water or juice, however some people in their room were not able to reach their drink which may result in them not receiving adequate fluids.

The home was warm, welcoming and decorated to a high standard. Corridors were well lit and carpeted in a

single colour with handrails throughout. The lounge area had recently been redecorated and refurbished with new chairs and carpet. The environment was clean and fresh smelling and bright and cheerful throughout. There was plenty of artwork and things of interest on the walls. There were displays placed around the building providing sensory stimulation. Some of these included a coat and hat stand complete with coats, hats and scarves. Memorabilia such as the old style telephones, radios, typewriter, guitar and a large poster of a telephone box on the stairs. The manager told us they had many more plans around the environment such as a life sized post box for people to post letters and also to make comments and suggestions about the service.

In the lounge there was a sweet shop laid out with sweets in jars and packets of crisp snacks. There was a sign saying "Please help yourself" and old fashioned weighing scales for people to weigh up a 'quarter' of sweets. There were comfort dolls and cuddly animals available. An aquarium, karaoke machine and wide screen television were also available. There were bookcases containing music CDs, puzzles and games and photograph albums for people to look at.

People told us they thought the environment had improved with one comment of "There have been improvements over the last few months. Redecoration and things rearranged (the lounge) was very dull and depressing". We found there was still a lack of signage on communal doors. Picture signs would help to inform the person of the purpose of the room and would help people with dementia to orientate themselves and maintain their level of independence.

People received support to remain healthy, from a range of healthcare professionals. We spoke with health care professionals present at the service during our inspection. This healthcare professional was a dementia specialist and their visits were regular. The purpose of the visit was to review people on dementia specific medicines and also to review people with mental health needs such as depression. They said the documentation such as 'Do Not Resuscitate' forms (DNAR) and blood results were up to date and accurate. It was further stated that the staff were receptive and there was good co-operation between them.

We spoke with an Occupational Therapist (OT) who told us the registered nurses made referrals for their input. They said their advice was always followed and stated "staff know people inside and out. They care. Activities are always going on. The food is good and catering staff are aware of people's dietary requirements".

Good

Is the service caring?

Our findings

Since the inspection in March 2016 we saw a positive improvement in how staff interacted with and spoke about people. Staff were mindful not to talk over people and used appropriate language when asking people if they required personal care. Staff interacted with people at a social level, talking about the news, everyday events or about people's recollections as they looked at some of the memorabilia dotted around the home. Staff acknowledged people as they entered a room and asked people how they were. Staff were kind and caring in their approach and supported people to maintain their dignity, for example asking one person if they could re-arrange their dress as it had slipped up.

People told us they were happy living at Wemyss Lodge and we noted people looked well cared for. People's rooms were all comfortably furnished, fairly spacious and light. All bedrooms were well personalised. Many had memory boxes outside with photographs and items which meant something to the person. This helped to orientate people to their room.

We received nothing but praise for the kindness, compassion and caring nature of the staff. Comments included "Better care than our family could give", "The quality of care is very good", "I'm happy that Mum is here", "Mum elected to come in here. I feel a lot happier she is in here. She gets her medicine when she needs it and sees her GP regularly", "We have peace of mind. No need to worry, nothing is too much trouble, they are constantly checking on Mum" and "First class, can't be improved upon".

People told us "They all call me by my Christian name. I came here for respite. I told my family I liked it, so here I am" and "They [the staff] all know me even though I don't know them". Other comments included "The girls are wonderful, how they keep their patience I don't know", "Staff are extremely good. Very caring. They have a really good attitude" and "Can't fault the staff, right through to include all of the staff".

We observed that people were treated respectfully and personal care was carried out in the privacy of the person's room. People told us "The care is wonderful", "You can have a little joke with them [the staff]", "I have confidence in them [the staff]. I feel I can talk to them and they can talk to me", "Very good. They listen to you. Gentle with you and respect you" and "They know how to look after me. Some staff are a bit thoughtless and move me roughly. I tell them straight away".

We received feedback from a local hospice about their experience of working with the home. The hospice worked intermittently with staff around people's end of life care and support and advanced care planning. They praised the way the home supported people at this time and found staff were caring and compassionate. They recalled how staff went out of their way to meet people's wishes, such as one person who wanted to fly on a micro-light plane and to go to a Christmas concert to listen to the choir. The home arranged for these activities and the person told them, they were happy they had "done what they set out to do" and were grateful to the staff for making this happen. A family told us "We had two homes lined up for palliative care but we didn't bother going to look at the second and we had a phone call from staff to say our loved one had arrived and everything was fine".

At lunch time we observed staff wiping each person's hands with a 'wet wipe' before the meal was served. Some people were not asked if they wished this and there was a blanket approach to this practice rather than considering if people either did not wish to wash their hands prior to lunch or preferred to use the communal facilities. This practice lacked a person centred approach and had little disregard for people rights to privacy and dignity. The manager said this practice was a suggestion from a health care professional and agreed it was not a person centred approach and they would be reviewing this.

On each floor of the home there were wet rooms. The rooms were only accessible using a key code. Throughout the inspection, the doors were locked which meant people did not have freedom of choice to have a shower without having to ask a member of staff. The manager told us they did not know why the wet room doors were locked and neither did the staff we asked. There was no risk assessment in place which demonstrated a potential risk to people or rationale for the door being closed. The manager told us they would be reviewing this and would risk assess this practice.

Requires Improvement

Is the service responsive?

Our findings

During the comprehensive inspection in March 2016, we found the content of the risk assessments and care plans lacked sufficient detail to enable staff to take a consistent approach to keeping people safe and ensuring the person's needs were met. At this inspection we found some improvement had been made, however the introduction of an electronic care recording system and a lack of robust implementation had hampered the progress of accurate and detailed person centred care plans being in place.

Information about people's care and treatment was not always person centred, accurate or up to date and did not always correlate between electronic and paper records. There was a lack of consistency in information about people's life histories, what they valued and their family connections. Care records did now always reflect how the person wished their care to be delivered and their preferences. With regard to monitoring people's care, one person was on hourly checks day and night. However a later care plan stated this was two hourly checks so there was an inconsistency in how often staff were checking this person. It was unclear why this had changed as the person was continuing to spend all their time in bed and the electronic records did not reflect the rationale behind these changes. Likewise, where people required repositioning, the changes were either not reflected in the electronic records or staff were not completing the checks as required.

The content of the risk assessments and care plans lacked sufficient detail to enable staff to take a consistent approach to keeping people safe and in ensuring the person's needs were met. In the care records we reviewed, non-descriptive instructions were given such as, weigh regularly, without a timescale given, needs to be assisted to the toilet regularly, without saying how often this should be, encourage fluid intake but not how this should be done and what the optimum level of fluid each day should be.

With regard to nutritional assessments, there were inconsistencies between the requirement forms for two people. For example, for one person the nutritional assessment said pureed diet but the 'resident's requirement form' stated soft diet. The room number of one person was incorrect and for another person with 'double pureed' diet it was added 'of sorbet' consistency. We noted that some people did not have a SaLT assessor or dietician involved but were served with a soft diet.

One person's nutrition and hydration plan stated they were unable to feed themselves and were on a soft diet with supplements and their diet was also fortified. On this person's room folder it stated that their food and fluid intake should be monitored. It was recorded 'Unsure how much weight lost or gained in a period of three to six months, but no appetite loss'. However this person's care plan stated they should be weighed monthly using the hoist scales as they were at 'Risk of malnutrition and poor diet'. The weight audit showed that this person had only been weighed three times since June 2016. This person had lost in three months a total of 24.6lbs. The online care plan however recorded that this person had last been weighed in February 2017 and their weight had increased slightly but they were still underweight in line with their BMI score. There was no information on what action had been taken to support this person from further weight loss. The home had not appropriately monitored this person. This person had also been put on a soft diet which had been decided by the home. There had been no involvement from the Speech and language team

(SaLT).

Where people had a fluid chart in place we found these had not always been added up to give a daily total to ensure sufficient fluids had been given and to offer more fluids if required. In addition, we found some people were not maintaining adequate levels of fluid which some charts showing a maximum of 570 and 650 mls a day total intake.

We saw one person's fall risk assessment had not been completed since July 2016 despite this person having had a serious fall in October 2016 resulting in a hip fracture. It was hard to ascertain a true representation of this person's mobility as not all assessments had been updated or fully completed. For example, on one assessment it stated in November 2016 staff had transferred this person using a hoist, slide sheet board and stand aid. However in January 2017 it stated transferring was not possible and no aids were used. This was not representative of what staff were doing as a hoist was being used. One person had sustained an injury whilst staff transferred them using a hoist. A risk assessment had not been put in place to mitigate the risks of this event occurring again and staff had not had their manual handling techniques reviewed as a result of the incident.

Preventative care had not always been considered. One person's sensory assessment stated that the person had very poor eyesight but no visual aids were in place. We then saw recorded in the electronic care plan that the person wore glasses, this contradicted earlier information. We met with this person and saw during our inspection they were not wearing their glasses to help their ability to see. Another person's care plan stated 'has glasses but tends not to use', there was nothing in place to support the person in these circumstances or how staff could encourage the person to wear their glasses when most needed.

One person's electronic care plan recorded they were not registered with the dentist, however had experienced bleeding from their mouth. There was no information recorded if any action had been taken around this, although the manager told us this had now healed. We found a lack of entries on the electronic system of details of people's dentist and this information was not in paper format.

People did not always have a risk assessment in place as required or the risk assessment in place was not sufficiently detailed to mitigate risks. One person had a chart, which showed particular behaviours they had shown. The information was not always factual or objective. For example, on one occasion, a member of staff had described the person's behaviour as 'not always co-operative'. For another person the description was given as 'agitated'. There was no explanation as to what these terms meant, what triggered the person's anxiety or how it was managed. Another care plan had identified a link between a person's pain and increase in confusion. However, this association had not been explored when the person's behavioural charts had been monitored.

A care plan stated the person's sense of touch was variable, without explaining what this meant for the person and how the person communicated the impact of this sensitivity.

One person in the home demonstrated frequent behaviour that could be challenging. This was mostly around receiving support with personal care. The care plan stated the person could demonstrate behaviours including 'Shouting, physical and verbally aggression, screaming, kicking, punching, biting and spitting'. The behaviour management assessment listed the triggers as physical contact and personal care and stated this person had been seen by the dementia team and tools in place were the Cohen Mansfield agitation inventory, Abbey pain scale and daily reports. We saw in this person's room folder an Antecedent-Behaviour-Consequence (ABC) Chart was in place to record behaviour incidents; however this had not been completed. The action stated that 'Staff are trained to use the safe holding technique when providing

essential care to [X]'. However this was not accurate, staff had not received this training. The manager told us they would be providing this training and there should have been an ABC chart in place.

The electronic care recording system enabled staff to input the emotional states of people, such as happy or anxious. However, there was a lack of information to clarify what the emotional state meant between each individual. This could therefore be open to the interpretation of the member of staff who assesses the person's emotional state, for example when completing the daily records. The registered manager told us "Staff know the people here very well, what may seem to you as a miserable day may be a good day for them. One person makes a 'Ne ne ne' noise and I haven't heard her do this for ages and that's a positive thing". After reviewing the electronic records we found there was insufficient explanation of people's emotional well-being, for example what people were communicating and how this related to their emotional state.

A 'resident' of the day process had been set up. This meant that one person was allocated that day to have their care and support needs reviewed. Care reviews involving the person and their family had not taken place. The manager told us "To be fair I have sent out letters, they have lapsed and got behind and that's been a lack of management consistency and the letter is to book a review with each person and their family. We had a meeting in December 2016 with families and it was very positive".

Each person had a personal care support plan which gave a profile of the person with a photo and information on their occupation, religion and reason for admission. Relationships with family were recorded. A registered nurse told us the care plans were devised by the registered nurses and there was a "residents of the day", which meant the records of the person identified were reviewed. They said there were handovers when shifts changed and staff were made aware of people's current needs when they arrived on duty.

Staff were not always responsive to people's needs. One person in a downstairs bedroom was calling for assistance. We entered the bedroom and noted the nurse call bell was out of reach and we were unable to summon staff support using the bell. We activated the sensor mat and a member of staff responded, this member of staff de-activated the mat, did not speak to the person and left. The person continued to call for staff support. We spoke to the member of staff and made them aware of their action. This person clearly needed support with personal care and needed staff to give them attention. Two staff then arrived to give the person attention.

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

Opportunities for people to engage socially had improved significantly. Some of the comments made to us included "I don't want to go down with other people. There's always something to fill my time and people to talk to, a visitor has just gone", "I choose to stay in my room. My daughter comes in every day", "There are enough activities for me. They are making a big effort" and "Always plenty of people at activities. Much more so than a year ago". Not everyone wanted to be involved in communal activities but this was respected by staff and people who chose to stay in their rooms said they were happy and staff popped in to see them regularly. Family and friends told us they were always made welcome and could visit whenever they wished.

During the first day of the inspection there was a sing-along to guitar music, the musician involved everyone, passing the microphone around for people to sing into. Most people were happy to join in and there was lots of staff interaction during this activity. People were engaged in either a small group quiz, watching television or some people preferred to doze in their armchair. We observed one person asleep who looked content in

their chair with a comfort cuddly cat and basket on their lap. One person told us "I spend most of my time in the lounge, I like TV and singing".

There were five activity co-ordinators in post. The activities co-ordinator we spoke with had started their role in late 2016 and told us they enjoyed their job tremendously. They are mentored each week and were soon going on a course around developing person centred activities. They told us that "improvements were being made all the time to the activity schedule" and that is was an "on-going work in progress". Numerous activities were available for people, such as flower arranging, painting, baking, karaoke, quizzes, arts and crafts, film shows. Outside entertainers also came in for group singing. A local dance school gave displays and the 'Sparkle' news sheet was printed daily. This gives information about activities and local news.

For people interested in growing flowers and vegetables, they were supported to go to the local garden allotments. The activity co-ordinator was organising travel vouchers through the local council to use towards trips out by taxi. A summer trip on a barge had been arranged and staff freely gave their time to volunteer to drive the mini bus when activities in the community were arranged.

All of the activities scheduled for the week were displayed in the lounge and foyer. Staff would ask each person what they would like to take part in. If people did not wish to participate we were told they could be encouraged to do something else of interest to them.

Activities are offered during the weekends and the activity co-ordinator told us they felt there were enough activity staff to cover in the event of annual leave or sickness. To ensure people confined to their bed were not socially isolated, there were three activity staff available in the afternoons. Two were based in the lounge for group activities and one would visit people in their room. They explained they take the sensory unit with them on one to one visits and also use the daily 'Sparkle' news sheet as an aid to conversation.

Daily evaluation forms were filled in and filed by activity staff. This included a description of the activity, the date, who attended and the group outcome (to include interaction, wellbeing, communication, and engagement), all of these were up to date.

The activities co-ordinator told us they were working with an occupational therapist to develop a 'resident forum' to engage people in putting forward ideas and suggestions for meaningful occupation and activities. They would also receive support with training, coaching and assistance to roll out the Pool Activity level PALS [PALS is a tool for assessing a person's level of ability for activities of daily living and for leisure activities].

We spoke with people and relatives about the process of making a complaint or raising a concern. No-one had made a formal complaint as they told us they felt able to voice any problems with the staff and felt they would be dealt with quickly. There was a complaint policy and procedure in place and this was available to people, families and visitors. A copy of the complaints policy was displayed in the foyer of the home.

Requires Improvement

Is the service well-led?

Our findings

During the inspection the registered manager informed us they would be de-registering with the Commission in order to concentrate on a more 'hands on' caring role. Following the inspection we received a notification to this effect. The new manager who had been in post since November 2016 was in the process of registering with the Commission to become the registered manager.

Since the last inspection in March 2016 there had been improvements to the running of the home, however further improvements were still required around leadership and accountability. Particularly around the transitional period between managers as it was unclear at times who held responsibility for decision making. As a result processes and systems were fragmented and staff did not always have a clear direction of leadership. The manager told us this should be resolved with the new management structure.

We saw that all the nurses including the registered manager had been issued a written warning from the new manager. This was due to errors in the administration of medicines and nursing staff not reporting incidents. The letter stated that 'All nurses complete a competency assessment, this to be achieved by the registered manager for day staff'. However the registered manager had also been served a written warning yet was to sign off the other nurses as competent again. This was not an appropriate responsibility for the registered manager to undertake given they had also received a written warning.

In March 2016 we found audits were not taking place in order to assess and monitor the standard of care delivered. We issued a warning notice to ensure the provider made improvements. During the focussed inspection in October 2016, we found immediate action had been taken to improve the auditing of the service. However, during the inspection in March 2017, these improvements had not fully been sustained.

A member of the nursing team was completing weekly and monthly medicine audits. These audits identified shortfalls in the safe administration of medicines; however an action plan had not been put in place to address the known shortfalls. In November 2016 the manager had started to take responsibility for some of the audits, these included financial, infection control, staffing levels, incidents and accidents and the admissions process. The facilities manager completed audits for the environment and health and safety. These audits were completed routinely. However, there was no oversight of what audits were required and when they should be completed and who should complete them. Therefore an improvement plan was not in place to address identified shortfalls. As from November 2016 there were ad hoc audits completed for falls, however other areas such as malnutrition and dehydration, care records, implementation of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, weights and pressure ulceration had not been completed. The training and supervision matrix had not been fully updated as additional records needed to be added.

The provider had introduced a computerised system for recording people's care and support in October 2016. We asked the manager if they had an implementation programme for the installation of the electronic data management system. We were informed there was no implementation plan in place. During our review of the electronic care records we found they did not always correlate to care given in practice, information

was missing and staff were not consistently inputting the data accurately.

The activity co-ordinators input the various activities people had taken part in onto the electronic system, however they were not able to view or generate a report about activities via this medium. An external consultant felt the "staff delivered good quality personalised care but were not recording their knowledge sufficiently on the electronic Care Docs system". Some elements of the electronic care system had not been set up and we found this lead to a lack of an audit trail when reviewing people's care.

Staff had received training in how to input information however there were no checks in place to ensure this was being completed accurately and consistently. The manager was the only person who was able to generate reports and this posed a risk of information not being accessible when required. The provider had failed to monitor if the electronic system was effective for its intended purpose and in enabling sufficient and accurate data to assess and monitor the quality of the service provided.

There was a process in place to ensure computerised personal data about people's care and treatment was kept confidential. The manager informed us the electronic hand held tablets used by staff were battery operated and were backed up each day using a pen drive. Only the manager had access to these pen drives for security purposes. The manager told us they did not have a policy or risk assessment in place which dealt with the handling of electronic data.

We spoke with the manager about the differences between what information was being recorded on the electronic data system and how this was reflected in the paper records. They told us "I think in six months I will be going back to paper, it's not a service [electronic data system] that I feel is beneficial to this home. To be fair I will speak with staff tomorrow and we are going to have a consultation and maybe remove the electronic system, and this would be done with immediate effect. We don't have a policy on electronic system. I have since spoke to care docs and they are going to outline the associated risks with it".

There was a lack of overview and information about the effectiveness of the activities people received. Activity levels were categorised into planned, exploratory, sensory and reflex and this was determined according to people's needs and abilities. The last time the levels were updated was in the September 2016 audit of activities. The current information held about people's interaction was not in line with the activity level audit of September 2016. This meant the provider did not have relevant information to be assured of the beneficial outcomes of the activities.

People's personal care records were not always being used in a confidential way. We observed the Medicine Administration Records (MAR) were left open when registered nurses moved away from the medicine trolley. We observed two registered nurses administering medicines on the ground floor and the file was left open on eight occasions. This meant people's confidentiality was not always respected because it was possible for people and visitors passing to read the medicines people were prescribed. People may not wish for their relatives and other visitors to know the medicines they were taking.

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

During the inspection the manager advised us of actions they were taking with regard to making improvements. This was confirmed by an external consultant. Improvements were planned for the care plans, audits, medication and in staff training to include understanding around the MCA Act 2005 and its implementation. A meeting had been arranged with a GP to review the process of referring to the speech and language team and referrals to local health agencies had increased, for example occupational health,

physiotherapy, dementia support and the dietician.

The provider had ensured that notifications they are required to submit to the Commission were completed where required.

People, relatives and others told us they were satisfied with the changes which had been made since the last inspection in March 2016 and felt this had been positive. People rated the quality of care they received as "Very good", "Ten out of ten", "Absolutely excellent" and "The staff are good and have improved immensely. More professional and very kind staff". There were Friend and Family meetings and families told us they were encouraged to be involved to voice their opinion about how the home was run with comments such as "There have been questionnaires and surveys in the past and there are residents meetings", "The last relatives meeting was very good", "We are encouraged to share views" and "Relatives meetings, yes but these are at 6 pm so I can't attend".

Staff told us they felt well supported in their role and were positive about the changes made. A registered nurse said they attended practitioner meetings and also attended a monthly general meeting. They said the manager was "fabulous". Another registered nurse said there had been many changes and many staff have left but "it's coming together."

A recent survey had been sent out to people and their families. The feedback was positive. A business plan was in place to develop and take the service forward. The provider held weekly meetings with the manager who also received non clinical supervision from an external consultant. The consultant would continue to provide an external auditing service to the home.