Wemyss Lodge Limited

Wemyss Lodge

Inspection report

Ermin Street
Stratton St. Margaret
Swindon
Wiltshire
SN3 4LH

Tel: 01793828227

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 14 and 15 March 2016 and the first day was unannounced.

Wemyss Lodge provides accommodation to people who require nursing and personal care. The home is registered to accommodate up to 60 people. On the day of our inspection, there were 57 people living at the home, some of whom were living with dementia. Wemyss Lodge has bedrooms on the ground and first floor. All rooms have an en-suite toilet and two bedrooms have access to a bathroom. There are five rooms which can be used for twin occupancy. A passenger lift is available for people with mobility difficulties. There is a communal lounge, large dining room and smaller dining room on the ground floor.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. 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 were not protected against the risk of unsafe or inappropriate care and treatment. Medicines were not organised and administered in a safe and competent manner and we found errors in the recording of prescribed drugs. Staff who administered medicines did not undertake an annual competency assessment to ensure they remained safe to administer medicines.

People were not protected against the risk of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. There was a lack of information and guidance for staff on how to support people safely and consistently.

Staff used unsafe moving and handling techniques which put people at risk of injury. Equipment was not appropriately checked to ensure it remained safe for people and staff to use.

Staff did not receive on-going support through a system of supervision and some staff had not received any supervision in 2015 and 2016. This included the clinical supervision of registered nurses. Appraisals were starting to take place in 2016. The trainer confirmed that mandatory training had fallen behind and they had recruited an additional trainer to support with this. Staff reported they felt supported and valued by the management team.

People told us they felt safe living at Wemyss Lodge and told us staff were kind and caring. We observed that staff were friendly towards people and most staff spoke to people in a respectful manner; however some staff practices and the language used when referring to people was not respectful.

There was a choice of drinks, snacks and meals available and people told us they enjoyed the food. The home had employed nutritional assistants to ensure people have sufficient hydration.

There were safeguarding and whistleblowing policies and procedures in place which provided guidance on the agencies to report concerns to. Staff had received training in safeguarding and whistleblowing to protect people from abuse and training records confirmed this.

There was a lack of audits in place used to assess, monitor and improve the quality, safety and welfare of people. Required audits such as in controlled medicines and infection control were not carried out. Gaps and shortfalls in the service provision were not identified. The registered manager did not have an overview of how the home was being managed and who had responsibility for various elements of this.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015. You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this provider is 'Inadequate'. This means that this service has been placed into 'Special measures' by CQC. The purpose of special measures is to: Ensure that providers found to be providing inadequate care significantly improve. Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made. Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not managed in a safe way.

People were left for periods of time unsupervised by care staff.

Not all care and other staff used safe moving and handling techniques when supporting people to move.

The registered manager had not submitted statutory notifications as required by the CQC in relation to incident reporting and safeguarding.

People told us they felt safe living at Wemyss Lodge.

Is the service effective?

Requires Improvement

The service was not effective.

Staff did not receive supervision in line with the provider policy. Staff training in refresher core subjects had not taken place as planned.

There was a lack of documentary evidence that people were involved in decision making especially where people did not have the capacity to consent to specific decisions.

People told us they enjoyed the food and the cook would always get them something different if they did not like the menu for that day.

Staff told us they received excellent training and felt they could approach any of the seniors if they had any questions around their practice.

Is the service caring?

Inadequate

The service was not always caring.

Some practices were institutionalised and demonstrated a lack of consideration for people as in how staff monitored people's

food and fluid intake.

Not all staff used appropriate and respectful language when referring to people who live in the home. Staff did not always ask the person's permission before placing a clothes protector on them.

Some information about people's care and treatment was not kept private.

Some people and families spoke highly of the staff. Staff told us they enjoyed their work and had built up positive relationships with people.

Is the service responsive?

Requires Improvement

The service was not responsive.

The care and treatment plans of people did not give sufficient detail around how staff should deliver care to ensure a consistent approach.

Timely referrals were not made to health professionals when required.

People who may be at risk of social isolation had not been identified or an appropriate action plan put in place to enable staff to reduce the risks of isolation.

Relatives told us they knew how to make a complaint.

People told us they took part in activities.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of audits in place to ensure the service was safe, effective and meeting people's needs.

The registered manager was not confident in their knowledge of the new fundamental standards of care which is a requirement of their registration.

The provider had failed to ensure the registered manager was appropriately supported through a process of supervision and development.

Staff felt valued and supported by the management team and

enjoyed working at the home.

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 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.

We carried out this inspection over two days on the 14 and 15 March 2016. The first day of the inspection was unannounced. Three inspectors carried out this inspection. One of the inspectors was a specialist professional advisor, this was a registered nurse specialising in dementia care. During our last inspection in September 2014 we found the provider satisfied the legal requirements in the areas that we looked at.

Before we visited we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We reviewed the Provider Information Return (PIR). 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 used a number of different methods to help us understand the experiences of people who use the service. This included talking with seven people who use the service and three visiting relatives about their views on the quality of the care and support being provided. During our inspection we observed how staff interacted with people using the service. We used the Short Observational Framework for Inspection (SOFI). We used this to help us see what people's experiences were. The tool allowed us to spend time watching what was going on in the service and helped us to record whether they had positive experiences.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included eleven care and support plans, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices.

During our inspection we spoke with twelve people and four relatives, the registered manager, deputy manager, the training manager and new trainer, other staff including registered nurses, care staff, office manager, housekeeping staff, the maintenance person and kitchen staff. Prior to and following the inspection we contacted health and social care professionals to find out their views about the service.

Inadequate

Is the service safe?

Our findings

Medicines were not managed and administered safely. Medicine which had been prescribed and dispensed for one person had been given to another person. The records evidenced that a registered nurse had given a specific pain relieving drug to one person but which belonged to another person and there had been an 11 hour delay in the person being given the pain relief. The nursing staff failed to ensure there were sufficient stocks in place and subsequently to request an emergency prescription. Nursing staff misused the prescription drugs in their charge and placed people in their care at risk as they did not have an oversight of the medical risks involved in such practice.

In both of the drug registers there were crossings out and different amounts written in. The drugs register was completed prior to the person being given their medicine. The Nursing Code of practice states '10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed and do not include unnecessary abbreviations, jargon or speculation'. In addition there is a requirement to 'communicate effectively, keeping clear and accurate records'. Some nursing staff were not adhering to their code of practice.

We reviewed the medicine records for 23 people and for 41 separate medicines. We found serious errors and evidence of poor practice in the administration and recording of medicines, in particular with specific prescribed drugs. For example, the dose given not being accurately subtracted from the total amount left available. There were two drug registers in place to record the stock levels. Entries for drugs administered were written on the wrong page and for one person against the wrong drug. When we audited the drugs given in the registers, there was a missing 300 ml bottle of morphine. After investigation, we found the registered nurse had failed to ascertain that this medicine had already been signed into the register before signing it in again. In this instance the error was due to recording; however this raised serious concerns about the accuracy of the recording and the signing in process, which meant the provider could not be assured that the stocks of medicines were accurate or were not being mis-used. Our concerns were further compounded because the registered manager had failed to ensure that these types of drugs were being audited.

The deputy manager told us the amount of storage available at this time was not sufficient for the number of medicines they held, in particular 'specific' types of medicines. They had recently ordered a new cabinet for these medicines because at the moment it was difficult to easily see what medicines were in stock. When we audited these medicines with the registered nurse they confirmed the number of medicines in stock did make it difficult to quickly locate what was required.
In addition medicines were not being disposed of in line with the provider 'Medicine Policy'.

Some people were prescribed variable doses in medicines, however no information was seen to guide staff what dose to administer. The specialist nursing assistant told us that they would ask the person what they felt they needed or they would look for non-verbal cues such as facial expressions or body language. Without clear guidance being in place, this relied upon individual staff members making a value judgement about the interpretation of body language and facial expressions and what these meant. This could result in

the person not being given the required dose and affect their wellbeing. Not all staff had signed the document to evidence sample signatures therefore we could not be assured that only trained and designated staff were administering medicines.

Staff who administered medicines received training in this; however, an annual competency check was not carried out to ensure they remained competent to administer medicines and understood any changes in legislation or practice.

Wemyss Lodge use a monitored dosage system and had the appropriate medicines trolley to transport medicines to people around the home. Senior staff who administered people's medicines were aware of the medicines that people received to manage known health issues. People's allergies were clearly recorded to ensure people were protected from possible harm.

The registered manager had failed to monitor and analyse accidents and incidents in order to mitigate the risk of further occurrences. Incidents and events occurring within the home were recorded in an accident book. There was insufficient information recorded about the actual incidents and how they had been managed. Furthermore, these incidents were being treated in isolation as the registered manager had not reviewed them for trends or reoccurring patterns in order to put measures in place to reduce further incidents. One example of this is the number of falls people sustained whilst in the lounge area, this had not been investigated.

On the evening of the 14 March 2016, there was an incident involving two people. The type of incident warranted an alert to be made to the local authority safeguarding team, which following the inspection we found had not been done. During the morning of 15 March 2016, we checked the care records for one person where a behaviour chart had been completed for an incident which occurred the night before. The registered manager and deputy manager were not aware of the incident as it had not been brought up in the morning handover session. Staff had not identified this as a potential safeguarding alert rather as part of the person's behaviour. The incident recording lacked sufficient detail about the event. The registered manager told us they would be reporting it to the safeguarding team. We followed this up with the Swindon safeguarding team and found it had not been reported. We asked the registered manager to complete and submit a statutory notification to the Care Quality Commission as required, however, this had not been done following the inspection.

Whilst we saw evidence of good manual handling practice, we also observed poor and unsafe practice from care and other staff. Non care staff who assisted people to move had received training in moving and handling. Staff did not always put the brake on the wheelchair to stabilise it before moving the person in or out of their wheelchair. A member of staff pushed a person in a wheelchair up an incline yet did not put the brake on whilst they opened the door. Care staff lifted people under their arms when assisting the person to get out of their chair. Another person was supported to get out of their chair by the care worker pulling their wrists to help them up. These practices could result in injury either of the person's shoulders, wrists or to the member of staff through back strain. The registered manager told us they observed staff practice yet there was no evidence poor manual handling had been raised as an issue.

There were a sufficient number of slings available to assist staff to support with people's moving and handling. However, the slings had not been maintained to ensure the safety of people who use the equipment. Many of the slings did not have clear instructions of use, washing and care as the labels had washed out. Four out of eight slings had not been tested as required by LOLER. (Lifting Operations and Lifting Equipment Regulations, Health and Safety Executive) which requires checks to be carried out every six months for equipment to support with lifting people. Failure to check this equipment may result in staff

using unsafe equipment which could compromise people's health, safety and welfare.

The home and the environment were clean and staff used appropriate protective equipment when carrying out personal care. However, there was a lack of systems in place to monitor and manage the prevention and control of infection. The registered manager did not carry out infection control audits which considered how susceptible people are and any risks that their environment, staff practice and others may pose to them. Therefore, the registered manager could not be assured that all staff are fully involved in the process of preventing and controlling infection.

The flooring in the kitchen posed an infection control hazard. The linoleum was lifting at the edges near the back door and the flooring join was coming apart to the left of the entrance door near the serving hatch. This could lead to bacteria forming in the cracks due to food debris and other waste substances settling in the crevices of the lifted linoleum.

The dishwasher in the kitchen stood on a waist height stand and the stand was rusty. The residue of rust had fallen onto the containers which were placed on the floor next to the dishwasher. Whereas, there is little risk of the bacteria from the rust spores being ingested through food, the risks to kitchen staff through either touching a rusty surface with an existing cut or cutting themselves on the rough surface of the rust had not been considered as a potential infection control risk.

Access to the ground and first floor shower rooms were by a key code pad. We were able to access these rooms without the key code as staff had left the doors open. This posed a risk to people if they were able to gain access to the rooms because of the nature of the items stored. In each of the shower rooms we saw five litre containers of body wash, shampoo and conditioner which were used communally and which were open. Chemicals such as bleach, de-scaler, carpet cleaner, general cleaner were also stored in the rooms, with some chemical having been decanted into bottles without a label identifying the contents. The cleaner told us they did not know why chemicals and cleaning products were stored in the communal wet rooms. This could mean that people may ingest or inappropriately use these items.

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

Staff that had the relevant skills and experience were not deployed in a manner which could potentially place people at risk of harm.

Two members of the inspection team overheard one person in the dining room who was coughing and then started to make choking sounds. As there were no care staff in the vicinity, one inspector went to assist whilst the other inspector went to find a member of staff. By the time the member of staff had arrived the person had calmed and stopped coughing. The registered manager could not be assured that had the incident involved a choking from a blockage, that timely support would have been available. On another occasion a nutritional worker was seen supporting people in the lounge area when they thought one person was having an epileptic seizure. The nutritionist was unaware of what to do and acted appropriately when they went to find a care worker for support, they subsequently sought the advise of a further two members of the care staff. The person was not having a seizure and the third member of staff explained the change in breathing was due to the fact the person had a shower earlier that morning. However, a delay in providing timely support may have had serious consequences had the person involved been having a seizure.

During the mornings on both days of our visit, people were left unsupervised in the lounge and dining room. Care staff supported people to move into the lounge area and we observed that the majority of people

required assistance to mobilise, be seated and to be made comfortable. On both days there were up to 21 and 18 people in the lounge and some people eating their breakfast in the dining room. Some care staff went in and out of the lounge but did not remain. At various times the three inspectors were situated in the lounge without any staff presence. We asked a member of staff where the care staff were and they responded "they are getting people up". They told us this was the usual practice to move people into the lounge so that staff could concentrate on getting other people up.

People remained in the lounge area without support from staff to access the toilet facilities. Staff did not come into the lounge periodically to ask people if they wished to use the toilet facilities. This may have contributed to a person being incontinent of urine. Whilst in the lounge we heard three people calling out for assistance and although people did have a call alarm around their neck, they were not being used. No staff were in the vicinity. One person said to us "is anyone around I want to move I am not comfortable [in their chair]". Another person told us they wanted to go back to their room; we saw them trying to catch the eye of a member of staff who walked through the lounge to the dining room, they were unsuccessful.

The registered manager told us they used a dependency tool to determine if people required nursing or residential care. They did not use any kind of system to calculate the number of staff they required when new people moved into the home or if people's needs changed. Staffing numbers were based on a minimum number of staff and they did not use agency staff when the staffing levels fell below this number as they preferred to use their existing staff. We reviewed the rotas for the day of the inspection and the previous two months. The rota's indicated that for each day the minimum number of seven care staff was met, however, the rota's had been written over and crossed out in pen. We could not be assured the rotas were accurate as the registered manager had already told us there were some days they did not meet their minimum number of staff. During the course of the inspection, people who used the calls bells in their room were responded to swiftly, however people told us that there can be a delay in staff's response especially if they are busy or short staffed.

Staff told us "we try and keep as many people in the lounge as possible so that staff can keep an eye on them" and "usually we have enough staff to meet everyone's needs unless staff are off sick. This happens frequently and at these times we manage". We discussed this with the registered manager who did not feel this was an issue. The arrangements in place for ensuring sufficient staff were available did not take into account people's individual needs and wishes. We reviewed the PIR information which the registered manager had sent prior to our inspection. There was contradictory information given around the staffing levels with the statement 'staffing levels are appropriate for service user's needs. Then when the question is asked about how the service is to be improved to make the service safer, the response is 'to increase staffing levels, trained and untrained'.

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

The recording of safe recruitment procedures was not fully effective. We audited 11 staff files during the inspection. One staff member did not have evidence of a full DBS (Disclosure Barring Service) certificate on file, yet they had been working at the home for over two years. The registered manager did not know if they had a current DBS in place. We followed this up with the office manager who stated they had tried to follow this up and had passed this onto the registered manager. It transpired that the employee had not shown evidence of the DBS to the office manager and this was the reason it had not been documented, however, the registered manager had failed to follow this up to ensure the member of staff was safe to work with vulnerable people.

The provider's recruitment policy stated that staff's DBS's would be renewed on an annual basis, however out of the 11 files we reviewed, eight staff members did not comply with this policy with some not having a renewed DBS since 2007. We were shown a copy of a letter which the registered provider was intending to send to all staff. This was a declaration for staff to sign to state there had been no changes since their last DBS check. This practice could mean that staff do not disclose any new convictions which may question their suitability to remain in their role and to be able to keep people safe.

People told us that they felt safe living at Wemyss Lodge.

The staff we spoke with were able to articulate the definition of abuse and to explain what action they would take in the event of them having a concern. Most staff had received training in safeguarding people. Comments from staff included "we have a duty of care not to hurt them [people] or put them at risk, they are the important person" and "it is my job to keep people safe, such as explaining why they may need bed rails".

Some people's health needs meant they required regular checks, for example to monitor INR levels. This is a test used to monitor the effects of warfarin called the International Normalised Ratio, or INR. It is a blood test that checks how long it takes for blood to clot. These tests were carried out by the registered nurses. Records demonstrated what doses to administer and senior staff used these to ensure people were administered their required medicines safely.

Walkways within the home were clutter free to enable people to walk around safely. There was a maintenance programme in place for repairs and redecoration of the home.

Requires Improvement

Is the service effective?

Our findings

Refresher training in the mandatory subjects as set by the provider was not being completed within the timescales set. The provider could therefore not be assured that staff were current in their knowledge and skills and that this was being applied in practice. For example, the implementation of the mental capacity act and consent, moving and handling practice and treating people with respect.

Staff told us they had completed all mandatory training, however records showed that subjects which required refreshing had not been attended as required by the provider. We spoke with the trainer who advised us they were 'behind' in their refresher training and had employed a second trainer who was currently going through their induction. Nursing staff were due for a refresher in vena puncture in December 2015 and this had not been completed. Twenty-one nursing and care staff had not renewed their pressure area care training as planned by the provider. Likewise, six members of staff had not renewed their training in wound dressing as planned for February 2016. Staff had last attended these training courses between 2013 and 2014.

The safeguarding training was due for renewal in January 2016; however this had not been completed and affected 42 members of staff. Likewise, 48 staff had not received an update in Mental Capacity Act (MCA) 2005 training which staff had previously completed between 2012 and 2015. The training matrix had not been updated to include new dates for the training missed so far.

The registered manager could not be assured that staff were receiving the required training. Seven members of staff ranging from a domestic assistant to a registered nurse had no training recorded on the matrix with the exception of training in 'people/objects'.

Staff told us that Wemyss lodge offered them excellent training opportunities and the way training was delivered was suited to them. For example, the trainer stated they used a combination of face to face training and computer based training. Staff told us they were supported to obtain qualifications in health and social care.

We requested a copy of the supervision timetable for 2015 and 2016 for all staff. We were not supplied with a 2016 timetable for the care and nursing staff, although some supervision for 2016 was listed on the 2015 timetable. The deputy manager told us they had fallen behind with staff supervision.

There was a lack of opportunities through staff supervision to review staffs' personal development and progress. The provider policy on staff supervision for laundry, housekeeping and catering staff states supervision should be carried out on a group and one to one basis. Out of 19 staff, seven staff had received one supervision in 2015 and seven staff had not received any supervision. In 2016, these staff had not received a supervision to date.

For nursing staff the provider policy states 'registered nurses employed by the care service are expected to receive clinical supervision to meet the Nursing and Midwifery Council (NMC) post-registration

requirements'. The registered manager and deputy manager told us they supervised each other with regards to clinical supervision. However, in 2015, six members of the nursing staff had not received any clinical or other supervision as required. As an overview of the staff supervision for 2015 including all staff roles, 43 members of staff had not received a supervision with only one staff member receiving the minimum standard set by the provider of four supervisions a year.

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

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).The registered manager told us that where required applications had been made on behalf of people for deprivation of liberty safeguards (DoLS) and some applications had been authorised.

There was a lack of recorded evidence of how people had been involved in the decision making process and that best interest meetings took place prior to the final decision being made. Not all of the mental capacity assessments in place were complete, were decision specific and gave a date for review. There was no evidence that capacity had been discussed during the person's care review to ensure the decision made previously was still valid.

Where families held a legal power of attorney (LPA) for health and welfare and finances they were involved in decision making regarding various aspects of the person's care and treatment. However, the registered manager had enabled families to make decisions on behalf of the person where the family did not hold the legal authority to do this or where evidence of the appropriate LPA had not been provided to ensure the registered manager was acting in the person's best interests.

We saw no evidence within any of the care records that where decisions were being made of behalf of people as a best interest decision, that the person themselves had been consulted and asked if they wished to be involved. For several people a decision was made to crush their medicine as this was to be given covertly (without their knowledge). The medication care plans state 'does not have capacity to make decisions regarding medication'. Yet there was no specific MCA carried out or evidence of best interest decision making.

There were some bedrooms in the home which were shared between two people. There was either a dividing wall partition in place or a curtain. We asked the deputy manager about one person who had moved from a single to a shared room and what the rationale for the move had been and if they had gained the person's consent. They responded that people did not object although they had not written this in the person's care plan. There was no documentary evidence that the lawful process had been followed in relation to the mental capacity act and where people could not give their consent that a best interest process was followed.

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

People had access to drinks throughout the day. Each person had a jug of water in their room and a water

cooler was located in the foyer of the home. Where people had a fluid chart in place these had been totalled to give the amount the person had drunk that day. The provider employed nutritional assistants to offer people drinks throughout the day and snacks if requested. People had the choice of eating their meals in their room or in the communal dining room.

We used the Short Observational Framework for Inspection (SOFI). We used this to help us see what people's experiences were. The tool allowed us to spend time watching what was going on in the service and helped us to record whether they had positive experiences. People spoke positively about the choice and quality of food provided. Comments included "The cook will make whatever food I ask" and "The food is delicious", however this was not always the case as we saw a person ask for scrambled eggs for breakfast and as they had none left, they were given cereal instead.

The cook was informed of people's specific dietary needs before they moved into the home and people's dietary intake was recorded daily. During the meal times we observed care staff enabling people to make a visual choice of meal by showing them the plate of food. However, this was not the same practice throughout the lunch time meal. On two tables, both staff members asked people what they would like to eat and told them the choice. Three people hesitated and the staff repeated the menu choice and then selected the meal option for each person. There were no picture menus available which would enable people time to visualise the meal before choosing.

Over fifty percent of people who currently live at Wemyss Lodge have dementia or a cognitive impairment and may have difficulties around orientation and spacial awareness. The environment did not promote people's independence and which we observed placed an over reliance on people requiring staff assistance, such as moving to and from their room. There was a lack of signage on doors to inform the person of the purpose of the room, such as picture signs. A communal toilet on the ground floor had a sign which said 'bathroom' which could be misleading to people. The hallways in the home lacked interest through sensory and other objects and the carpet in the main lounge of the home was dark with an intricate pattern. This may affect how people mobilise or deter independent movement.

Inadequate

Is the service caring?

Our findings

Not all staff treated people in a respectful manner. During lunch time we observed a practice which was institutionalised and demonstrated a lack of consideration for people. A member of care staff sat at a table without firstly asking the two people already sat at the table if they could join them. Without speaking to either person, the care worker referred to a list and looking around the dining room, ticked against the names of people who had eaten their meal. They then left the table, again without saying anything to either person. Later they returned and carried out the same procedure and this time another member of staff joined them and stood over the table to read the list. This member of staff did not engage with the two people who were eating their lunch. Sometime later we observed a different care worker stand in the middle of the dining room, looking around the room and ticking the list if people had eaten their meal.

Before people were served their meal, not all staff asked the person for their consent to wear a clothes protector. Some staff placed the clothes protectors on people without speaking to them before moving onto the next person at the table and where they repeated the exercise.

When speaking about people's care to other members of staff, not all staff were respectful in the language they used. Staff shouted across the lounge "I'm feeding" to refer to people they were going to assist to eat and drink. In front of the registered manager a member of staff referred to the 'feeder table'. The registered manager did not react or respond to this statement. Staff spoke over the top of people referring to them as 'he' or 'she' for example when a care worker shouted to another care worker "is she going in a chair?" When staff supported people to eat and drink, some staff were stood over the top of the person rather than sat at the person's level to enable eye contact and to make the experience a social one. During the previous year there had been two similar complaints made by people and their families regarding a lack of respect shown from staff. The action taken was to remind staff over a period of seven days to be more respectful towards people. However, this response had not altered how some staff treated people.

When people entered the lounge in their wheelchair some people were not asked if they would like to be transferred into an armchair. Out of seven people who were wheelchair users, we saw only one person was transferred into an armchair. People were not repositioned yet spent several hours sitting in the same position in their wheelchair. We asked a member of staff to assist one person who was looking particularly uncomfortable. We observed people as they spent their time in the lounge. Over the two mornings of our visit, we found most people were asleep and there was little interaction from staff because staff were busy elsewhere. One person told us "they [staff] are all busy so there isn't really anyone to talk to".

The practice employed by staff to wash and dry people's hair did not protect people's dignity or afford them respect. There was a washroom which was available for the hairdresser to use for washing people's hair. When people had their hair washed they would sit in the corridor to have their hair dried. We observed a line of three people, two of whom were in a wheelchair. The first person was having their hair dried, whilst the other two people sat and waited in their wheelchair behind each other. The hairdresser told us this had always been the practice and they did not think it infringed upon people's dignity having their hair done in a public space or to be lined up in such a way.

Wemyss Lodge is registered to provide personal and nursing care for up to 60 people. At the time of our inspection there were 57 people living in the home. People had a separate toilet in their room but do not have en-suite bathing facilities such as a bath or shower. We were told there were two bedrooms which had access to a bathroom and for the remaining two floors of the home there were three communal wet rooms for people to use. This equates to one communal wash room for every 19 people.

The deputy manager stated they had decided to have all wet rooms as people did not want to use a bath, although we saw no documentary evidence that people had been consulted with and asked for their preference. This meant that people currently living at Wemyss Lodge or new people moving into the home did not have the choice of a bath or shower. Displayed in the shower rooms were the weekly rota's stating the room number and the day allocated for the person to have a shower. This demonstrated an institutionalised approach to bathing and resulted in people having a body wash and weekly shower rather than the option of a daily shower or bath.

There were practices which failed to ensure people's information about their care and treatment was kept private. Where people were required to be 'Nil by mouth', a sign was placed on the outside of the bedroom door or outer wall of the room. This meant that anyone walking by would see the sign and know the person's treatment. With regards to care records, each person had a shortened version of their care plan. These were seen in people's rooms and in corridors. As most people had their bedroom door open, the information was easily accessible to people walking past as they were placed on a table just inside the door. One person had placed their care plan and charts outside of their room on a window sill. The registered manager told us the person did not like the paperwork to be in her room, however, an alternative place where the records would be secure and only accessible to the relevant people had not been considered.

This was a breach of Regulation 10, Dignity and Respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that "staff were helpful and very respectful of my privacy" and "staff are very good". A visitor told us "I have nothing but praise for the staff who work so hard here". A relative stated "the home is lovely, if it wasn't, I would have taken her away 2 ½ years ago. I have never heard a member of staff raise their voice, really calm and relaxed and my mother has threatened to slap them. 'I can visit anytime, no restrictions". Other comments from relatives included "Mum has been here 15 months and couldn't be in a better place" and "Mum has been here 5 years at end of the month, it is the best place. I don't think she would still be with us if not for care here' 'I can't speak highly enough".

Staff told us they enjoyed working at the home and had built up good relationships with people and staff.

Requires Improvement

Is the service responsive?

Our findings

We reviewed the care records of 11 people. The information gathered prior to the person being admitted to the home was thorough. Subsequent risk assessments and care plans were then devised to determine the care and support people 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 all of the care records we reviewed, non descriptive instructions were given such as, weigh regularly, without a timescale given, keep hydrated, without how this would be achieved, ensure water temperature is correct without saying what a safe water temperature would be.

Where specific care needs had been identified there was a lack of information about how and what support was required. Such as, where poor nutritional intake had been identified and a nutritional risk assessment and plan of care was not in place for this. Other examples where a need had been identified and care plans had not been completed were for eye sight, mobility, mental health and well-being, skin integrity, oral hygiene, psychological needs and social isolation. A falls risk assessment had not been completed correctly for one person. They were identified as not being at risk of falls yet their prescribed medicine could increase their risk of falls. We took a random sample of monitoring records belonging to five people. Three of the monitoring forms had not been completed as required. There were gaps in the timings of when people were due to be checked with staff. This either meant that people were not being checked upon as required or staff had not completed the records at the time of the checks.

We reviewed records documenting visits or contact between the service and external professionals or families. These records showed an inclusive approach to meeting the needs of the people that use the service, however referrals were not always made and in a timely way. One person had sustained continued weight loss over a period of time and the person was on a food recording chart; fortified foods and snacks. However, no referral to a dietician had been made and the person continued to lose weight.

Where people exhibited behaviours which may challenge there was insufficient guidance available to staff to be able to effectively manage the behaviours. For two people the current guidance had not reduced the pattern or frequency of behaviours. Records did not give clear information about the triggers for behaviour and what staff should be mindful of. There was a lack of strategies in place to support people and to enable a consistent approach from staff. One person exhibited sometimes aggressive behaviours towards others. There was a lack of monitoring around these behaviours such as in behaviour charts and a recent visit from the dementia specialist team had assessed the need to monitor, which the staff had failed to do.

Staff were not always aware of what interventions had been recommended for people and were not following the advice of external health and social care professionals. For example, a recommendation had been made to massage a person's hands with lavender oil to try and reduce in the behaviour of the person slapping their head. Staff told us they were not aware of the regime. During our observation of this person we saw they repeatedly slapped their head with their hands. One member of staff approached the person to try and calm them, other staff ignored this person's behaviour. One member of staff told us "they always do that".

Wemyss Lodge employed one full time activities co-ordinator to provide each person with the appropriate stimulation. There was an activities schedule on the noticeboard in the entrance hall and also the monthly newsletter contained information pertaining to the activities that were planned that particular month, such as pub trips, painting, bingo, church services and live entertainment. A member of staff told us that due to only one person employed to provide activities to 60 people they felt this did not provide the appropriate stimulation to each person. This placed people at risk of social isolation. People who may be at risk of social isolation had not been identified or an appropriate action plan put in place to enable staff to reduce the risks of isolation.

Relatives told us they did not always feel that activities were available or suitable for everyone, and one relative told us "Some residents do not have enough stimulation". During the two days of our inspection we saw people participating in a parachute game and people meeting in the lounge getting ready to go out for lunch. Other people remained seated in a chair in the lounge, some watched television, however, most people spent prolonged periods of time sleeping (one or two hours at a time).

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

The deputy manager told us they had recently reviewed and rewritten all of the care plans. Care plans were reviewed monthly or when people's needs changed, for example, following a change in their health conditions.

People told us they knew how to make a complaint and a relative told us "I know who to speak to if I had a concern, I find them [the staff] very approachable".

Inadequate

Is the service well-led?

Our findings

There was a lack of leadership and direction in the home. During our inspection we found the registered manager was not confident in their knowledge around what management and quality assurance systems and processes were in place and which members of staff held responsibility for various tasks. The registered manager did not have an overview of how the home was being run and the quality of the service provided. This was in relation to the auditing and monitoring of the service, supervision of staff and training, awareness of best practice and in the requirements of a registered manager with the Care Quality Commission. Gaps in the service provision had not been identified by the registered provider or registered manager through a quality assurance system, therefore an action plan was not in place to address these concerns and failings.

We asked the registered manager to tell us about the new fundamental standards of care which came into force through the Health and Social Care Act 2008 in April 2015. We also asked them about the new regulation 20, 'Duty of Candour' and the new offence of 'ill treatment and wilful neglect'. The registered manager told us "the house trainer may well have done duty of candour and wilful neglect training but not sure and staff probably don't know because we haven't passed it on". The registered manager was not able to discuss any aspects of the new health and social care standards.

The registered manager stated they were going to look at the 'new standards'. However, it is a legal requirement of their registration to implement the new standards and ensure that staff are working to these standards. We spoke with care and other staff and found they were not aware of the new legislation and the standards expected of them in their role. Wemyss Lodge was therefore not being managed in line with current legislation.

The provider policies had been updated to include the new regulations relating to the fundamental standards of care. However they were not dated and signed off and the registered manager had not read them. Sections within some of the policies required a named person to be entered, for example the lead for infection control. This and others had not been completed.

We asked the registered manager if the provider themselves or an external person from a consultancy or from another of the provider locations or managers visited the home to carry out audits. They told us they did not and this contradicted the information given to us in the PIR return we received prior to the inspection. This stated that in the 'last 12 months, there had been four visits to assess the quality of the care provision by senior managers and/or internal quality auditors not directly located at the service and reports and action plans were in place as a result'. We found no evidence of external audits taking place.

The provider had failed to ensure the registered manager was supervised in their role. This concern had been raised previously by the Swindon contracts team following their visit.

There was a lack of cohesive systems in place to assess, monitor and evaluate the service provided to people. We asked the registered manager if they carried out an infection control audit. As Wemyss Lodge

provides nursing care this is an essential element of ensuring safe infection control practices are followed. The registered manager was not able to tell us and referred us to the house trainer. We spoke with the house trainer who directed us back to the registered manager. Likewise, the registered manager could not advise us on the audits which were taking place within the home.

The registered manager did not have a schedule of audits in place stating which audits were to be carried out, by whom and how often. Some audits were taking place on a random basis and were not being documented in a way which enabled the registered manager to measure the safety, effectiveness and standard of care and treatment people received. We reviewed the medicine audit which reviewed how the Medicine Administration Records were being completed. This audit was not robust enough to reduce potential risks to people and it did not include controlled medicines. The last medicine audit was completed in October 2015; however, this did not specifically audit all areas of the safe administration and management of medicines. The deputy manager told us they had recently completed a 'thorough check of the medicines'. However, they had not documented this information to inform planning and quality assurance and their check had not identified the issues we found.

There were cleaning schedules in place which included health and safety in the kitchen; however, this had not identified the issues we found in relation to the dishwasher and potential infection control hazards in the kitchen. No infection control audits were taking place to ensure clinical and other staff practices were safe. There were a lack of audits in relation to the checks made on slings used to support people to mobilise.

With regard to the management and support of staff, there were no audits in place to inform the registered manager of how often staff received supervision and the outcomes. In particular, relating to the supervision of clinical staff and if they were practising effectively and safely. Staff training and the effectiveness of the training had not been audited; therefore the registered manager could not be assured of the skill base and knowledge of the staff. The registered manager told us they observed staff practices as part of quality assurance, however, there were no records of this and the concerns we found were not identified.

There was no system in place to determine if safe and sufficient numbers of staff were allocated and deployed and no evidence that staffing levels were monitored based upon people's needs.

Incidents and accidents had not been analysed collectively in order to reduce further occurrences, for example in relation to how, when and why the incidents and accidents were occurring. The quality of record keeping such as for care plans were not audited to ensure they were relevant, current and person centred.

At a clinical level, the registered manager confirmed they 'were not sure' if they had information in the way of audits relating to pressure ulceration, infections, nutrition, hydration and weight loss which would inform their planning and development of the service. Where people had sustained falls there was a lack of individual and collective analysis. The deputy manager provided us with a graph which they told us was an audit for 'falls', however, the graph did not provide sufficient information to inform planning. We reviewed an audit of mattresses/bedrails/beds which had been completed in March 2015. This audit was used as a preventative tool to reduce the risks of pressure ulceration. The audit was thorough in terms of this equipment and the deputy manager told us this was due again this month.

In relation to people's mental health and well-being and potential social isolation, no assessment or evaluation of the current activity provision had been carried out in order to improve the service if required.

In the foyer of the home was a notice advising people and relatives how they could make a complaint,

however the information was out of date and was not accurate as it directed people to the care quality commission regarding their individual complaints and not to the ombudsman or local authority in the first instance. The display on a noticeboard in the foyer of the home contained information in the form of a tree telling people about the care standards which as a registered provider with the CQC, the home must adhere to. However, these were the old standards which are no longer being used having been superseded by the change in legislation in April 2015.

People and families were able to give their views about the quality of service they received through a comments form, however, the responses had not been collated with an action plan to address any shortfalls. For example, a relative had stated about their concerns with people being left in their wheelchairs whilst in the lounge. We also raised concerns with the deputy manager as this practice was still continuing.

An inspection visit by the Swindon contracts team advised that although feedback forms were sent out on an annual basis there was no formal feedback available which gave the results and outcomes of people's experiences of living in the home.

The provider had failed to inform the Care Quality Commission of a change in their nominated individual and of changes to their contact details through a statement of purpose.

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

Staff were very positive about Wemyss Lodge and told us they felt valued by the management team. Comments included "I have been here two years and there has never been a day when I did not want to come into work" and "I am really proud to work here, I feel that we are all encouraged to reach our potential". Staff told us they felt supported by the registered manager and the deputy manager, comments included "you can approach them at any time and they are willing to listen" and "I have been through a lot personally and I couldn't have been supported more".

There was a system in place for dealing with complaints and a policy and procedure on how the provider would respond to complaints. People told us they said they would speak to the registered manager if they had any concerns. One relative said "I would not hold back if I had a problem with the care or treatment that my mother was getting".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care 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. Records were not being completed accurately and timely referrals made to health professionals. There was a lack of consideration for people who may be at risk of isolation due to a lack of social stimulation. Regulation 9, (1) (a) (b) (c) (3) (b) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff did not always treat people with respect and did not refer to people in an appropriate manner. Not all staff gained consent from people before support was given and people were not consulted regarding their preferences for personal hygiene routines. People's information about their care and treatment was not kept private. Regulation 10 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent There was no documentary evidence that the lawful process had been followed in relation to the mental capacity act 2005 and where people could not give their consent that a best interest process was followed. Families made decisions

around people's health and welfare without the registered manager having evidence that a Lasting Power of Attorney in health and welfare was in place. Regulation 11 (1) (2) (3) (4)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed and administered safely. There was a lack of systems in place to appropriately identify safeguarding risks and to monitor incidents and accidents. Equipment which was used to support people to mobilise was not checked to ensure it was safe to use. Staff used unsafe and inappropriate manual handling techniques. People had access to the 'wet rooms' which contained chemicals and other unsafe products if ingested and we found infection control concerns in the kitchen.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager was not confident in their knowledge of the systems and processes in place. A system of regular audits was not in place. Wemyss Lodge was not being managed in line with current legislation of the new fundamental standards of care which came into effect in April 2015. The provider had failed to ensure that the registered manager was appropriately supported through supervision. Notifications were not submitted as required by the registered manager and provider.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff with the relevant skills and experience were

Diagnostic and screening procedures

Treatment of disease, disorder or injury

not deployed in a manner which offered people appropriate supervision and support. There was no system in place to ensure that staffing levels met the current needs of people living in the home. Staff had not received supervision in a timely manner and mandatory refresher training had fallen behind.

The enforcement action we took:

Warning notice