Wemyss Lodge Limited

Wemyss Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 4 and 5 December 2017. The first day of our visit was unannounced. This meant the provider and staff did not know we would be visiting.

Wemyss Lodge Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to accommodate and provide nursing care to up to 60 people. 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. On the day of the inspection, there were 46 people living at the service.

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.

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 some improvements had not been sustained and further shortfalls were identified.

When we completed the last inspection in March 2017 we found some improvements. The management of medicines had improved although there were still areas which required improvement. 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. Improvements were required around the implementation of the Mental Capacity Act 2005 and how care records underpinned the Act.

In March 2017, we also found 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. Mandatory training as set by the provider had not been completed within the timescale required of the provider. Processes and systems were fragmented and staff did not always have a clear direction of leadership.

During the inspection in March 2017 we identified five breaches of the Health and Social Care Act 2008 (Regulated Activity) Regulation 2014. We imposed a condition on the provider's registration to submit

monthly audits to the CQC to ensure the quality of the service was being monitored.

At this inspection in December 2017 we found improvements had been made. People using the service told us they felt safe living at Wemyss Lodge. Relatives we spoke with agreed they were safe living there. People were kept safe from avoidable harm because the staff team had received training on safeguarding and understood their responsibilities. They knew what to look out for if they suspected that someone was at risk of harm and knew who to report their concerns to.

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. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The risks associated with people's care and support had been assessed and reviewed. People received their medicines as prescribed. We have made a recommendation about the storage of some medicines.

Appropriate pre-employment checks had been carried out on new members of staff to make sure they were safe and suitable to work there. An induction into the service had been provided and on-going training was being delivered. This enabled the staff team to gain the skills and knowledge they needed in order to meet people's needs. There were sufficient staff to meet people's needs and spend time with them.

People were provided with a clean and comfortable place to live. There were appropriate spaces to enable people to either spend time with others, or on their own.

Staff were supported through annual appraisals and a number of supervisions throughout the year. Staff told us that they felt supported by the registered manager and that communication was effective. Staff were aware of their duties under the Mental Capacity Act 2005. Staff obtained people's consent before carrying out care tasks. Legal requirements had not always been followed where people did not have the capacity to consent. We have made a recommendation that the provider consult with guidance to ensure consent is only given by those with the appropriate authority.

People who used the service and relatives consistently told us staff were caring, patient and upheld people's dignity. People felt consulted and listened to about how their care would be delivered. Care plans were personalised and centred on people's preferences, views and experiences as well as their care and support needs.

People who used the service knew how to complain, and who to. Complaints were investigated and responses given.

Auditing and quality assurance systems took place to monitor the quality of the service so that action could be taken where identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were aware of their responsibilities in keeping people safe.

People told us they felt safe. Relatives told us they felt their family member was safe.

Appropriate arrangements were in place for the safe administration and disposal of medicines. We made a recommendation that the service consider current guidance on storing medications safely and take action to update their practice accordingly.

Sufficient numbers of staff were provided to safely and effectively meet people's needs. Staff recruitment procedures and checks in operation promoted people's safety.

People had individual risk assessments and all identified risks were assessed and ways to reduce the likelihood of the person being harmed were considered.

Is the service effective?

Good

The service was effective.

Staff were provided with a regular programme of training, supervision and appraisal for development and support.

Staff knew about people's health needs and personal preferences and give people as much choice and control as possible.

We have made a recommendation that the provider consult with guidance to ensure consent is only given by those with the appropriate authority.

People were provided with access to relevant health professionals to support their health needs.

The home was well maintained and comfortably furnished.

Is the service caring?

Good

The service was caring.

Staff respected people's privacy and dignity and knew people's preferences well.

People living at the home, and their relatives, said staff were very caring in their approach.

Is the service responsive?

Good

The service was responsive.

People's care plans contained a range of information and had been reviewed to keep them up to date.

People living at the home, or their relatives, were confident in reporting concerns to the registered manager and felt they would be listened to.

A programme of activities was in place so people were provided with a range of leisure opportunities.

Is the service well-led?

Good

People, relatives and staff said the registered manager was approachable and communication was good within the service.

There were quality assurance and audit processes in place to make sure the home was running safely.

People and relatives views were actively sought to continuously improve the service.

The service had a full range of policies and procedures available for staff so they had access to important information.

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.

This inspection took place on 4 and 5 December 2017. The first day of our visit was unannounced. The inspection was carried out by two inspectors, a pharmacy inspector 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. Their area of expertise was older people.

Prior to our inspection, the provider had completed a Provider Information Return [PIR]. This is a form that asks them to give some key information about the service, what the service does well and improvements they plan to make. We looked at the PIR before our visit and took this into account when we made judgements in this report. We also reviewed other information that we held about the service such as notifications. These detail events which happened at the service that the provider is required to tell us about.

Ahead of, and during our inspection we had received concerns around the conduct of the registered manager and the quality of care being provided to people. The provider investigated these concerns thoroughly and provided a comprehensive response. At our inspection we did not find information to suggest these concerns were founded.

At the time of our inspection there were 46 people living at the service. We were able to speak with 12 people living there and nine relatives. We also spoke with the registered manager, the deputy manager, the matron, senior nurse, nursing assistant, six care staff, the activity co-ordinator, the chef and the maintenance person.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed support being provided in the communal areas of the service. This was so we could understand people's experiences. By observing the

care received, we could determine whether or not they were comfortable with the support they were provided with.

We reviewed a range of records about people's care and how the service was managed. This included three people's plans of care. We also looked at four people's medicines records and reviewed how the medicines systems. We also looked at associated documents including risk assessments. We looked at records of meetings, recruitment checks carried out for four members of staff and the quality assurance audits the management team had completed.

Good

Is the service safe?

Our findings

At the previous CQC inspection in March 2017 we identified concerns that the provider had not ensured the proper and safe use of medicines. We also found some risk assessments were not in place or did not contain sufficient guidance to staff. These were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following this inspection, we imposed a condition on the provider's registration requiring them to complete and submit to CQC, a monthly audit and action plan to show what they were doing to improve this key question to at least good.

During this inspection on 4 and 5 December 2017 we found the provider had made improvements. Where medicines required refrigeration, the fridge temperatures had been recorded daily. However, the minimum and maximum fridge temperature had not been recorded correctly. This meant it was not certain that medicines were stored at the correct temperature to ensure their effectiveness.

We recommend that the service consider current guidance on storing medications safely and take action to update their practice accordingly.

Arrangements for ordering and disposing of medicines were reviewed and we saw that these were managed safely. There were suitable arrangements for storing medicines which required extra security. Regular checks of these were made and no issues were identified. The service had worked with the local Clinical Commissioning Group medicines team and the supplying pharmacy to make the required improvements.

We checked four people's medication administration records (MAR) and saw they had been fully completed to evidence medicines had been administered correctly. We observed medicines administration for four people and they were given in a safe and caring way. Creams and other external preparations were recorded on a separate topical administration chart (TMAR). These had been completed to show the cream had been applied as it had been directed.

Protocols for medicines that were to be taken when required were available and detailed when the medicines could be given. Staff could offer non-prescription medicines in response people's minor symptoms. This was covered by their policy and a record was kept when any medicine was supplied. There was also a policy in place to support people to look after their own medicines. One person was self-medicating their inhalers and a risk assessment had been completed.

Some people were receiving covert medication. Documentation was in place to show that people's mental capacity had been assessed and a best interest decision made with the involvement of the GP and family members. Pharmaceutical advice had also been sought on the best way to administer these medicines. We saw that some people were receiving medicines that were mixed with food or drink to make them more palatable. This was being done at their request and advice had been sought on the suitability of this.

Medicines audits were completed monthly with weekly MAR audits focusing on three residents each time. There was evidence to show that action plans were being followed up.

People's care files contained assessments relating to risks such as falls, moving and handling, pressure sores, malnutrition and dehydration. We saw people being supported to mobilise safely in line with their care plan guidance and action had been taken in order to reduce risk. For example, one person had been assessed as being at risk from developing pressure sores. We found that they had been provided with an air pressure mattress and that the inflation pressure of the mattress was set at a level appropriate for the person's weight. Records were kept of positional changes and those we saw indicated that staff changed the person's position every three to four hours as recommended. The person did not have any pressure sores. Where people had been assessed as being unable to use their call bell to summon help, we undertook three observations, and along with records seen, these indicated that hourly checks on their safety were being carried out.

People and their relatives told us they felt safe in the home and that staff were trustworthy and sufficiently skilled to keep them safe. One person said, "Yes feel very safe - my own little world. Staff here I can talk to, have a chat about this and that." Another said, "Just get hold of [staff name]. She tells someone else and things sorted out." We had positive comments from relatives such as, "'It is a safe place. Cope well with his complex needs." People knew how to raise concerns if they felt unsafe.

Staff had received training in safeguarding adults and understood their responsibilities to identify and report any concerns. Staff were confident that action would be taken if they raised any concerns relating to potential abuse. Staff comments included; "Any concerns and I'd go to my manager and the local authority", and "I'd tell the manager, safeguarding or the police". There were safeguarding procedures in place and records showed that all concerns had been taken seriously, fully investigated and appropriate action taken. Training in other areas to keep people safe such as understanding, preventing and managing behaviours that may challenge had taken place.

There were sufficient staff on duty with the required skills to meet people's needs. Staff were not rushed in their duties and had time to sit and chat with people. During our inspection we saw people's requests for support were responded to promptly. We spoke with a senior nurse and senior care assistant who felt the staffing levels were adequate to meet people's needs.

We saw a range of pre-employment checks were in place, such as Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals. This helps employers make safer recruiting decisions and employ only suitable people who can work with potentially vulnerable adults.

The service evidenced that they analysed information so that learning could be taken from incidents such as falls or medication errors. When falls occurred actions had been put in place to reduce these by making referrals to health professionals. We saw that where some staff occasionally forgot to sign medicine records, the issue was discussed with staff and prompts were placed in handover sheets and 'routine schedule sheets'. One staff member said, "This works". Records confirmed incidents of staff forgetting to sign medicine records had greatly reduced and we found no errors on the records we looked at.

People were protected from the risk of infection. Infection control policies and procedures were in place and we observed staff following safe practice. Personal protective equipment (PPE) was available and we saw staff wearing protective aprons and gloves before personal care. The home was clean and free from malodours. A person's relative said that they always found the room "pristine."

We saw that the premises and equipment had been maintained in line with policy. There were detailed maintenance records that showed equipment and the environment was monitored. These included fire

precautions with checks on emergency lighting, emergency evacuation drills and weekly alarm tests. The fire alarm system and fire extinguishers had been serviced and a fire risk assessment carried out by external consultants and we saw actions had been taken where required. Electrical, gas, water safety had been checked in line with policy to ensure safety. Equipment used for moving people had been maintained and serviced to keep people safe.

Good

Is the service effective?

Our findings

At the previous CQC inspection in March 2017 we identified concerns that the provider had not followed the principles of the Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found that mandatory training detailed by the provider was not being completed within the timescales set by the provider. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection, we imposed a condition on the provider's registration requiring them to complete and submit to CQC, a monthly audit and action plan to show what they were doing to improve this key question to at least good.

During this inspection on 4 and 5 December 2017 we found the provider had made some improvements. However, we did note that some consent forms relating to people's care and treatment had been signed by the person's next of kin. People are unable to sign consent on behalf of others unless the service has a copy of an authorised Power of Attorney document. We saw that two people's relatives had power of attorney for finances but not health and welfare so could not agree to people's consent to care and treatment. This had not had any direct negative impact on the people's care.

We recommend that the service consults with the MCA Code of Practice to ensure all procedures are followed to ensure consent is legally sought.

Staff had received training on the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. A nurse confirmed that they had received training relating to mental capacity. A care assistant also told us they had received training and described how decisions made in people's best interests should involve the person, their family, the GP, nurses and social workers. They mentioned that the outcome should be the "least restrictive" for the person.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. This procedure is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any DoLS applications had been made to the local authority. A DoLS application had been requested for a person who lacked capacity in areas of care such as support with nutrition and hydration, use of bedrails and bumpers, care and hygiene, continence, medicines, mobility and equipment; and being 'nursed in bed.' Therefore, authorisation was required in order to meet the person's care needs where they could not consent.

People using the service had their care and support needs assessed. The registered manager explained that whenever possible an assessment would be carried out prior to a person moving into the service. This ensured their needs could be met by the staff team. We spoke with people and their relatives who said they had contributed to their care planning through informal conversations with staff and formal care reviews.

The staff team had a good knowledge and understanding of the needs of the people they were supporting. The staff team had received an induction into the service when they first started working there and relevant training had been provided. This included training in the safeguarding of adults and equality and diversity. We spoke with a nurse who had received training in relation to medicines management, urinary catheterisation and end of life care. Care staff completed the care certificate (a benchmark that has been set for the induction of new healthcare assistants and social care support workers and is therefore what we should expect to see as good practice from providers.) The staff team were supported through supervision and appraisal and they told us they felt supported by the management team. A member of staff said "We talk about our goals, the service and any changes; and about training." Another said "I have had a couple (supervisions) since I started. They are useful and I was able to talk things through." This meant the staff team could support the people using the service safely and effectively.

People were supported to maintain a healthy and balanced diet and they told us the meals served were good. We spoke with the chef who was pro-active in meeting residents to discuss changes to the menu based on peoples 'preferences. People told us the chef would prepare alternatives if they didn't like something on the menu. We received comments such as, "Nice casserole. Enjoyed it" and "Food alright and can choose what you like. Will do other things if you want. A relative said, "Choice of two mains and two puds. If she is not happy with the meal they take it away and change it for something else without any fuss."

Where people had specific dietary needs, these were catered for. People had been assessed in respect of risks associated with eating such as weight loss or choking. We saw one person at risk of malnutrition had been records of food and fluid kept, had been weighed monthly and records showed minimal weight loss over a twelve month period. Details relating to the correct consistency of thickened drinks were available, and included the amount of prescribed thickener required. Staff we spoke with were able to tell us the correct amount of thickener used in the persons drinks.

We saw that people ate where they chose, including their bedrooms, dining room or lounge. Where people ate together, we saw it was a social time with lots of chatting and interaction between them.

People were able to access care, support and treatment in a timely way with referrals made to appropriate health services when people's needs changed. We saw records of visits and letters from healthcare professionals, such as general practitioners, dieticians, community mental health team, tissue viability nurse specialists and speech and language therapists (SALT) were seen in peoples care files. For example, we saw SALT assessments had been carried out on people who may have swallowing difficulties. We saw results of these were passed to the chef to ensure the necessary textured meals were prepared.

People had access to suitable indoor and outdoor spaces. There were spaces available for people to meet with others or simply to be alone.

Good

Is the service caring?

Our findings

We observed and heard that people were treated in a kind and positive manner and there was a warm and friendly atmosphere. Staff had developed good relationships with people and we saw people were relaxed in the company of staff, who communicated spontaneously with them, using appropriate humour. All the people we spoke with were positive when asked if they felt cared for and happy. Without exception we were told this was the case. Comments included, "Nothing to grumble about, lovely and comfortable', "'Yes nice and kind. Couldn't be any kinder" and "Quite happy with the care. They do everything you want and put themselves out. Kind caring people."

Relatives spoken with told us they felt the staff were kind and caring. Comments included, "Care staff here very, very good. Can't find one fault with any of them", "Take their time [care staff] half an hour, three quarters of an hour - whatever it takes", "Can leave her here knowing that she is safe. Wonderful care - always has been. As gradually she has got frailer, taken more care of her."

The staff team had the information they needed to provide individualised care and support because they had access to people's plans of care. These included details about people's past history, their personal preferences and their likes and dislikes.

Staff sought accessible ways to communicate with people. We saw staff using a variety of techniques, written, verbal and non-verbal, to communicate with people. People's communication needs had been considered on an individual basis and we saw in one situation that a person had been provided with a wipe clean board so that both they and staff could use written communication to ensure their needs were understood. This meant people's opportunity to communicate effectively had been considered by the service.

We saw and were told that peoples' privacy and dignity was respected. We saw staff knocking on people's doors before entering and closing them before delivering care. People told us, "Do knock on the door. Privacy if you want it", "'Respectful when showering me. Very kind and considerate" and "Sit in my room. I want to be alone. Girls understand and respect my privacy." We saw care staff listening to what people wanted and acting promptly to their requests. We observed people were dressed well and attention paid to people's hair and oral hygiene. People said that they could choose the gender of their carers. This meant the service had taken people's preferences and needs into account when scheduling staff.

Staff instinctively responded where people were emotionally upset. For example, a member of staff spent time with a person who was lost and was becoming anxious. The member of care staff focused on the person rather than the task, providing reassurance in a compassionate way.

People were supported to express their views and were involved in making decisions which were respected. During the day we saw that people were making a variety of choices. People were choosing meals, who they sat by, when they needed personal care, where they wanted to go and what they wanted to do in the way of activities. We saw that people could choose to go to their rooms when they wanted to. A person said, "I like

to sleep with my windows open at night and the heating off. My choice and staff respect that." Another person said, "Not a lover of eating with other people. Dinner in my room –my choice, understand that. Bring in meals to my room." We saw people were able to choose where they spent their time, for example, in their bedroom or the communal areas. This showed people were treated respectfully. People were able to bring personal items with them and we saw people had personalised their bedrooms according to their individual choice. This also showed people were treated respectfully.

We saw that records containing people's personal information were kept secure. Where information was stored on a computer, the service complied with the Data Protection Act.

Good

Is the service responsive?

Our findings

At the previous CQC inspection in March 2017 we identified concerns that people's care records had not always contained sufficient detail, were not always person centred and records kept on an electronic system and paper records had conflicting information. Following this inspection, we imposed a condition on the provider's registration requiring them to complete and submit to CQC, a monthly audit and action plan to show what they were doing to improve this key question to at least good.

During this inspection on 4 and 5 December 2017 we found the provider had made improvements. The service had ensured care records were person centred to meet people's needs. Staff had responded to people's needs in relation to protected characteristics. For example, staff provided support to meet the diverse needs of people using the service including those related to disability. These needs were recorded in care plans and all staff we spoke to knew the needs of each person well. Staff had also supported people to improve and maintain relationships with their families to overcome potential barriers caused by people's diversity.

People had care plans in place that were based on assessments of their needs. A new care plan system had been introduced following the last inspection. Care plans seen covered needs such as personal care, moving and handling, cognition, social needs, medicine management, nutrition, communication and sleeping. Where a person had a specific need, such as support managing epilepsy, then care plans specific to that were in place. Another person had been admitted to the home with a grade four pressure sore. There were comprehensive records of the wound care and treatment the person had received, including photographs. The person had been assessed by a tissue viability nurse specialist. The wound was reported as healing and now at grade two. This meant care plans had been acted upon. Information relating to people's needs was also available in their rooms so that staff could have a quick reference guide. A nurse commented "We have a new care plan system now but some still need updating. There's also improved documentation in their rooms." This ensured that people received the care they required as care plans were clear and up to date.

People's interests, both past and present, were valued, respected and supported by staff. Activities were organised and led by a coordinator and comprised of painting sessions, arts and crafts, fitness sessions, floor games, films and a range of 1 to 1 activities. The programme was supported by a variety of specialist entertainers including a guitarist, singers, Music for Health, a fitness instructor, an organist and a water colour painter. People with a previous interest in art, cookery, knitting activities and dancing had the opportunity to continue with these activities. People were encouraged to maintain contact with the local community by attending regular events at the local community centre, such as tea dances, lunch clubs and sing alongs. One person who was a keen knitter had been brought in wool by a member of staff who was on their day off but had gone and brought wool for the person and taken it to them. The person was thrilled.

Trips out to local places of interest were organised on a regular basis. For example, canal boat rides, visits to a local wild life park, garden centre visits, events at the steam museum and theatre visits. Activities were arranged to enable people to follow previous personal interests or try new things. For example, people with an interest in gardening were able to be involved in gardening activities. Wemyss Lodge had been allocated

a wheelchair accessible raised bed on a nearby allotment. This has been constructed by the local allotment group, many of whom offered support to residents who wished to come to the allotment. Residents were involved in planting flowers and vegetables, maintaining the garden and harvesting crops. We were told about a person who arrived with not much interest in doing anything. We heard they now did knitting for a charity, visiting the allotment, painting money boxes and attending the lunch club. We had comments from people such as, "Enjoy chatting. Friends come up here. Do lots of knitting to benefit the home", "Local school came in and sang carols. Very good sing", "Try to join in. Lovely sing-song. Knitting for the fete, Christmas decorations", "Been on lots of trips out. Nice to get out" and "Plenty to do-never bored with here."

Links with schools were seen as important. A local school visited to give performances and people also visited the school to watch productions. Work experience placements were offered and in one case a pupil, who went to Wemyss Lodge on the programme, continued as a volunteer once the placement had ended and now works as a care in the home.

People's spiritual needs were met. People had the opportunity to attend services led by the local vicar. In addition members of the local church visited the service to talk with people. At the request of a resident, the Salvation Army pay regular visits. A resident had visits from a nurse's friends who could converse with the person in their own language. Written records, based on the Jane Poole participation scale and photographs provide evidence of peoples' participation in the activity programme and are used by the coordinator to monitor participation and develop further activities. This meant people were recognised as unique individuals and enabled them to live full and meaningful lives.

People and their relatives knew how to make a complaint or raise concerns. However, people and relatives we spoke with had not raised major concerns. They said that small things were dealt with immediately by nurses/care staff. A relative said, "Anything wrong, contact us straight away. (Relative) scratched a lot. Straight in the care plan and told us what they are doing." Another said, "Told if there are any problems."

We saw copies of the complaints procedure clearly displayed which contained information on how to complain and who to contact externally if it was felt the complaint had not been resolved satisfactorily.

We reviewed people's experience when they were approaching the end of their lives. People's preferences and choices at end of life were explored. Staff caring for people reaching the end of their lives, had access to support and training from a local hospice. We spoke with a relative and a person whose spouse had received end of life care in Wemyss Lodge and they said they had both received good end of life care. A relative told us, "End of life care beautiful. Not just looking after [relative], but looking after the whole family. Given me a room to stay in." Another said, "'Excellent to my (spouse). Had very good end of life care here. All loved here."

Good

Is the service well-led?

Our findings

At the previous CQC inspection in March 2017 we identified concerns that the provider had not undertaken actions, such as identifying areas that had impacted upon the safe administration of medicines. Staff did not always have a clear direction of leadership. This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014. We imposed a condition to require the provider to submit monthly reports to us to demonstrate that they were implementing a system to monitor and improve the quality of the service.

During this inspection on 4 and 5 December 2017 we saw these areas were improving. The provider had co-operated with the condition placed on their registration to provide monthly audits to the CQC. During this inspection we reviewed progress and found all areas of the service were regularly checked by the registered manager. This demonstrated the provider had addressed the breach of legislation since our last inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had been in post six months and had been supported by the provider to address the concerns found at the previous inspections.

Following the last inspection, the provider and registered manager had taken action to improve the management of Wemyss Lodge. The registered manager and staff understood the challenges of ensuring the service improved. A member of staff said, "We were devastated by the last report. Since (registered manager) took over we've had our ups and downs but it's working. The home looks better and we seem to have more time." They added "The (staff) that have left now want to come back." All the people and staff we spoke with talked about and displayed a positive, caring attitude and it was clear in the responses from people we spoke with throughout the inspection that the culture of the service was a caring one that was focussed on delivering good standards of care. People told us they felt the service was well led. Comments included; "As far as I am concerned it is well organised" and "It is organised and managed very well. The Deputy manager is also very good".

Staff told us they felt supported and listened to. Staff comments included: "[Deputy manager] is brilliant, she is my mentor. She always asks how I am doing"; "The deputy manager is very supportive. I will always go to her. She listens and things get sorted"; "[Deputy manager] tries her hardest to make sure things go well. I can't fault her. I am really well supported" and "I get the opportunity to have my say and queries always get sorted". The registered manager had moved their office to be more accessible and visible to people, relatives and staff. A relative said, 'Manager available and competent. Recently moved office to be more visible"

Staff said they were kept up to date and informed immediately about any changes or concerns. Systems for sharing information within the staff team were effective. There were regular staff meetings and a handover between staff when staff came on duty. They confirmed that staff meetings were held "every month. It was

more frequently at first. They (management) put across what needed to be done; they were honest from the start and I think they have gained the respect of the staff."

We observed staff on the day of the inspection and noted that the staff team worked collaboratively. Staff supported each other, instinctively or when asked and were friendly towards each other and often joined in appropriate banter with residents, creating a good atmosphere. A relative said, 'Carers work happily together-lots of friendliness between them, strong family atmosphere.' Another said, "Relaxed atmosphere. Staff don't get ratty. A warm welcome for us."

Staff described a positive culture within the service. One staff member said "I've seen an improvement with the new managers. They're open and supportive." Another said, They said of the manager "You can go to (registered manager) with anything. People seem happy again."

There were regular meetings for people to give them the opportunity to provide feedback on the service. People said their views were sought. We saw monthly meetings took place to seek their views on activities and food and any other issues they wanted to express. We saw action had been taken to provide activities of many varieties. One person said, "Have come along and gone through things with me. All sorts of questions [feedback questionnaire]." A relative said, "Chat to the manager, comment and things get done. Manager comes back and explains what has been done." Another said, "Any problems can go straight to the manager. When things go wrong sorted out."
A senior nurse said that the manager had introduced regular registered nurse governance meetings. These were initially held weekly, following the previous CQC inspection, but were now usually monthly or earlier if required. They said they discussed clinical issues raised by the inspection along with other relevant nursing issues and outcomes of audits. They cited the introduction of medicine cabinets in people's rooms and neurological observations following all unwitnessed falls, as changes instigated following these meetings. They said that there had also been an increase in the number of care plans that had been reviewed with the families of people who lacked capacity. They said "I'm learning all the time now. There's loads of support (from management). We need to keep going."

We noted improvements in the quality assurance systems to both monitor and improve the governance of the service. Audits on all areas of the service were taking place, and action plans in place to ensure any shortfalls were addressed to improve performance. The manager provided a copy of the outcome of audits undertaken by herself, the deputy manager and the facilities manager. Audits covered health and safety, tissue viability, infections, DoLS and MCA, advocacy, catering, administration, human resources and dependency ratios. A comprehensive 'Home Manager Audit' had been undertaken, which related to CQC domains of safe, effective, caring, responsive and well led. Actions to be achieved were recorded along with target dates and named the person responsible for achieving outcomes. We found the actions relating to the tissue viability audit had been achieved in relation to the care files we reviewed containing monthly risk assessments, wound care plans and tissue viability care plans.

Other recommendations put in place following audit findings included the introduction of daily checks of personal care provision and people's rooms by senior care staff. Records seen in people's rooms and the comments of staff indicated that these were being carried out.