Wemyss Lodge Limited

Wemyss Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Wemyss Lodge is a residential care home providing personal and nursing care to 46 people at the time of the inspection. The service is registered to support up to 60 people. The care home accommodates 33 people across the main building and 13 in a separate unit specialising in support for people with more complex needs such as mental health, brain injury and dementia.

People's experience of using this service and what we found
At this inspection we found systems and processes in place were not effective in providing an overview of areas of the service that needed improvement. Systems in place had not identified the issues we found during the inspection.

Medicines were not always managed safely. Risks to people were not always assessed and managed effectively. Staff did not always receive effective training to ensure they had the skills and knowledge to meet people's needs.

Staff provided mixed comments about the registered manager's approach. We raised this with the registered manager during the inspection.

People's and staff members views were sought but there was not always evidence these were used to help improve the service.

We received positive feedback from people's relatives about the care and support their family members received at Wemyss Lodge. Comments included, "I'm thrilled with how they look after him. I'm so pleased with the attitude, care, and kindness of the care staff, all of them cleaners, office staff, carers"; "The staff we speak to all seem professional, caring, patient, they really do care about their residents" and "They are well informed, and they know about [person's] needs and personality. They know how to be with [person]. I know from talking to them that they know [person] as well as I do".

We also received positive feedback from health and social care professionals that worked with the service to provide support and joined up care for people.

Relatives told us they felt their loved ones were safe living at Wemyss Lodge. Staff understood how to keep people safe from harm or abuse and understood their responsibility to raise concerns if they were to witness poor or abusive practice.

The provider had processes in place to ensure effective infection control and prevention during the Covid-19 pandemic.

The team worked effectively in partnership with other agencies to support people at the home.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 10 January 2018).

Why we inspected
We received concerns in relation to the management of some areas of Wemyss Lodge including medicines safety and risks. We also received concerns about the manner in which the registered manager interacted with staff. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well Led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Wemyss Lodge on our website at www.cqc.org.uk.

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service to keep people safe and to hold providers to account where it is necessary for us to do so.

We identified two breaches in relation to the safe management of risks and medicines and governance of the service at this inspection.

Please see the action we have told the provider to take at the end of this report.

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. If we receive any concerning information, we will use our current methodology to re-inspect the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Wemyss Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors, a specialist advisor 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.

Service and service type
Wemyss Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection took place on 22 September 2020 and was announced by telephoning the service just before entering the site to check their Covid-19 status.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We looked at notifications we had received. Notifications are information about important events the service is required to send us by law. We used the information the provider sent us in the provider information return. This is

information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We reviewed a range of records, including six people's care records and a variety of records relating to the management of the service, including training data, quality assurance records and policies and procedures. We spoke with 12 relatives by phone about their experience of the care provided. We used all of this information to plan our inspection.

During the inspection
On the day of the inspection, we spoke with one person who used the service. We also spoke with the registered manager, deputy manager, three nurses, one care worker, chef, and three members of the housekeeping and maintenance team.

We looked at seven people's medication records. We also looked at three staff files in relation to recruitment and staff supervision

After the inspection
We sought feedback via email from all members of care staff and spoke with nine of these over the phone following the inspection. We sought feedback from 12 health and social care professionals to gather their views about the service. We continued to seek clarification from the registered manager to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety.

Using medicines safely

- People were at risk because staff did not always administer medicines safely or people did not receive them as prescribed. Guidance about when to use when required (PRN) medicines was not kept with people's Medicines Administration Records (MAR). This meant that there was a risk that people may not receive their PRN medicines when needed it or it may be given inappropriately. For example, a person was not always assessed for pain relief in line with their care plan.
- People's care records were not always accurate which put people at risk of not receiving medicines as prescribed. For example, ensuring the medicines dispensed were correct to treat the person's condition and that instructions were clear about when to administer the medicine.
- Where people had been prescribed creams, we found records had not been completed on a number of occasions to show where creams should be applied and recorded to show it had been applied.

We found no evidence that people had been harmed however, we were not assured that the management of medicines was safe. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Information about risks and safety was not always comprehensive or up to date. For example, one person's nutrition care plan did not contain up to date guidance from the Speech and Language Therapist (SALT). A member of staff told us they had not seen care plans and said they were kept in the nurse's station. Therefore, information on people's nutritional needs were not readily available to staff to refer to.
- Where people were diagnosed with specific conditions, such as diabetes and epilepsy, their care plans were not always completed in line with national guidance. For example, a diabetes care plan had no details of symptoms of low or high blood sugar and there was incorrect information which stated weekly blood glucose testing took place instead of monthly. The deputy manager agreed to ensure this was put into place and to update all care plans for specific conditions, so they reflected best practice guidance.
- People's safety had not always been appropriately monitored. A person's care plan stated they should be repositioned every two to three hours to prevent skin breakdown. There were no records to evidence this repositioning was taking place.

We found no evidence that people had been harmed however, not all measures had been undertaken to safely manage and reduce assessed risks. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Not all staff had an induction when starting at the service and stated they were not given the opportunity to read care plans before supporting individuals. Staff comments included, "No, I didn't see [care plans] before working with people" and "I didn't have an induction at all. Not even shown where the fire escapes were. No introduction to paperwork and found it difficult to get my head around it. No clear care plans and have to wade through a lot of paperwork to find out what is needed".

● Not all staff had the qualifications, competence and skills to provide care safely. Staff did not always receive training to ensure they had the skills and knowledge to support people safely. Staff supported people who could display behaviours that may challenge themselves and others. Staff had not always been trained in how to support people to manage these behaviours. Some staff told us they worked with people who had behaviours that could challenge with no proper induction or training. This placed staff and those they supported at risk of unsafe practice.

● Some staff told us they did not feel they always had sufficient numbers of staff to support people to stay safe. Comments included, "Staff can be short at weekends", "After 4 pm we only have three staff on a floor and there is a lot to do at this time" and "Shortage of staff which makes me angry as puts pressure on care staff and not fair on residents". Staff told us absences were not always covered with appropriately skilled staff if staff went absent at short notice. Some staff told us they often did not know which people they would be supporting until the shift started. Some felt this impacted on getting to know people's needs well and consistency for people with staff they knew.

● Turnover of staff was high which meant people's care and support could be inconsistent. Whistleblowing concerns we received had stated a large number of staff had left over the previous year and three of the whistleblowers stated they had left after working in the service for a short period of time. A relative told us, "They have a high turnover of staff and that upsets [person], the fact that [person] has got to know people, and then they leave". We saw that exit interviews were offered but there was not a take up of these.

We found no evidence that people had been harmed however, staff had not been assured as suitably qualified, competent and receiving appropriate support to carry out the duties they were employed to perform. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● There was a lack of systems to ensure all risks were up to date and information was robust to manage the risks. This meant there was not a reliable system to identify where improvements were required, and an action plan implemented to ensure these were completed.

Systems and processes to safeguard people from the risk of abuse

● The service had safeguarding systems in place and appropriate policies and procedures to manage safeguarding concerns. Relatives told us their loved ones felt safe. Comments included, "Overall, it's very good, I have no worries, it's a friendly place and [name] likes it there" and "He is definitely safe, and he feels safe, which he hasn't always done in his life".

● Staff had an awareness and understanding of abuse and knew what to do to make sure that concerns were reported and of how to escalate these externally if necessary.

● Where there were concerns about a person's rights to freedom, the appropriate measures had been taken by applying for a Deprivation of Liberty Safeguard. This helped to ensure that the rights of people to be kept free from harm were agreed by taking into account the person's best interests.

● Relatives felt comfortable raising concerns about their relative's safety. Comments included, "I think they would get on top of any problems or complaints. I have never complained, but I know the manager would get it sorted if I did" and "If I say anything, they take note of it and check up on it, any issues they deal with. If

I raised an issue, they would investigate it, they are all very professional".

Preventing and controlling infection
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed. All relatives commented on how well the home had managed the Covid-19 situation.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Governance and performance management was not always reliable and effective. Systems had not always identified, managed or reviewed risks to safety. For example, systems had not identified the issues found during this inspection.
- The system to record, manage and follow up concerns about risks and safety were not streamlined to ensure an overview. There was a mixture of electronic and handwritten records which were difficult to decipher in some cases. This practice could place people at risk of harm as there was a limited assurance of clearly identifying any areas of improvement such as PRN management. The registered manager informed us that the home was moving to electronic records in all parts of the home.
- The provider had not ensured all staff were fully competent before carrying out their roles and responsibilities.
- Feedback to staff was not always provided in an effective manner so that they fully understood their roles and responsibilities. This meant not all staff were always clear about what they needed to do to improve.
- The provider had not notified us of changes to their Statement of Purpose to ensure that the document contained accurate details of the people being supported at the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Not all staff felt they could raise concerns internally. Prior to the inspection CQC was contacted by a number of 'whistleblowers'. Whistleblowers are staff who have concerns about the care being provided by their employer. Whistleblowing can cover any risk, malpractice or wrongdoing that affects people, the public, other staff or the provider. In law, whistleblowers are people who raise their concerns in a certain way and may receive protection in any employment dispute. The provider assured us that the concerns raised were being addressed.
- The provider carried out surveys with people, relatives, staff and professionals. However, no action was taken as a result of the surveys to improve the service.

Due to poor governance of the service people were placed at risk of not receiving good care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good

outcomes for people

● The provider and registered manager had not ensured there was an open, transparent and positive culture at the service. Some staff did not always feel listened to, respected, valued or supported and reported low morale. This meant there was a risk staff would be afraid to raise concerns.

● We received mixed feedback from staff about the registered manager's management style. Although staff commented positively about the registered manager's commitment to providing a high quality of care to residents, some staff told us they experienced or observed the registered manager raising their voice and using an inappropriate language and tone when speaking with staff on occasions.

● The registered manager demonstrated a commitment to ensuring the service was safe and of high quality.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● People's relatives said they were notified of all incidents. A relative commented, "They have always let me know about any problems straight away. I phone up regularly, I've had some video calls. [Person] can't respond but the carers will talk to me about how [person] has been".

● The Care Quality Commission (CQC) sets out specific requirements that providers must follow when things go wrong. This includes informing people and their relatives about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The registered manager was aware of her responsibilities.

Working in partnership with others

● We heard from health and social care professionals that the service was transparent and worked in partnership to support care provision and joined-up care. Comments included, "[Registered manager] is very involved with the care of every patient. She knows the residents thoroughly and is a fierce advocate for them. She is approachable and when I have had concerns she has always listened and responded. She thoroughly supports a multidisciplinary team (MDT) approach and has been instrumental in developing the MDT I attend weekly when I manage the medical needs of the residents".

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failure to effectively and mitigate risk, ensure systems were in place and have robust medication procedures, put people at increased risk of harm. Reg 12 (2) (a) (b) (c) (f) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to operate systems and processes effectively to ensure compliance with regulations, put people at increased risk of harm. Reg 17 (2) (a) (b) (c) (e) (f)