DCSL Limited

Soham Lodge

Inspection report

Soham Bypass
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Ratings

Is the service safe?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 19 March 2015. One breach of legal requirements was found. This was because the storage, administration and recording of medication did not always protect people against the risks associated with unsafe use and management of medicines.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook this focused inspection on 1 December 2015 to check that they had followed their plan and to confirm that they now met legal requirements.

This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Soham Lodge on our website at www.cqc.org.uk.

Soham Lodge provides accommodation for up to 26 people who require personal care or nursing care. The home provides support for older people, some of whom are living with dementia. There were 24 people living in the home at the time of our inspection.

There was a new manager in post at the time of the inspection but they were not yet registered with the commission. 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.

At our focussed inspection on 1 December 2015 we found that the provider had followed most of their plan which they told us would be completed by 10 June 2015 and legal requirements had been met.

Summary of findings

Since the last inspection changes had been made so that people had sufficient medicines available in the home. They were supported to take their medicines at the prescribed time and in line with the prescriber's instructions.

Training in medicine administration could not be evidenced and was to be completed again on 19 January 2016.

Medicines were stored safely and at the correct temperature and audits had been completed.

The processes in place to audit systems were not robust enough. This meant that the provider was not able to assess, monitor and improve the quality and safety of the service.

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Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

We found that action had been taken to improve the safety of the service.

People were supported to take their medicines at the prescribed time and in line with the prescribers instructions. Medicines were stored safely and at the correct temperature.

Whilst improvements had been made we have not revised the rating for this

key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

We will review our rating for safe at the next comprehensive inspection.

Requires improvement

Is the service well-led?
The service was not well led.

Audits of medication and medication administration records did not provide the accurate information that was needed to review and improve the service.

Requires improvement

Soham 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. We undertook an unannounced focused inspection of Soham Lodge on 1 December 2015. This inspection was completed to check that improvements to meet legal requirements, planned by the provider after our comprehensive inspection carried out on 19 March 2015, had been made. We inspected the service against one of the five questions we ask about services: is the service safe? This is because the service was not meeting some legal requirements in relation to that question. As a result of this inspection we also inspected the service against another of the five questions: is the service well led?

The inspection was undertaken by one inspector. Before the inspection we looked at all of the information that we held about the home. This included the provider's action plan, which set out the action they would take to meet legal requirements. The information we held also included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law.

During the inspection we spoke with one person living in the home and three registered nurses. We also spoke with the manager and the provider. We looked at seven people's medication administration records (MAR).

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of Soham Lodge on 19 March 2015 we found that people were not always protected against the risks associated with unsafe use and management of medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (f) & (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our focused inspection of 1 December 2015 we found that the provider had followed most of the action plan they had sent to us to meet shortfalls in relation to the requirements of Regulation 13 and 12 described above.

At the last inspection on 19 March 2015 we found that the storage temperature of medicines was not checked. We noted that the availability and administration of some medicines were not as prescribed by the GP and recording of medication did not always protect people against the risks associated with unsafe use and management of medicines.

We were informed that only registered nurses administered medicines to people living in the home. One person said, "The staff [nurses] give me my medicine. I don't have to worry about what to take or when."

We found that people had the medicines they needed available in the home. We found that where medicines needed to be administered in a specific way this was now being done. For example two nurses we spoke with confirmed that the nurse on night duty administered medicines, prescribed by the GP, which needed to be given before other medicines or food. Detailed protocols were in place for medicines given as required.

Where new medicines had been prescribed and handwritten information was added to the MAR's this had been checked and countersigned by a second member of staff. However on one MAR, three hand written medicines had been crossed through. There was nothing written by the person who had recorded the medicines on the MAR to say why the medicines had been deleted from the person's list. This had not been picked up by the senior carer who had checked the MARs on that day. The head of care said that the person did not take any of the medicines and therefore believed that it was an error of recording. They said that the reason for the deletion should have been recorded on the MAR.

Since the last inspection we found that there were daily audits for the temperature of the medicine room and medicines fridge. All temperatures were within the expected limits.

There was a destroyed/returned medicine ledger but we found that medicines had not always been recorded as such. One nurse said that a person had spat their medicines out. The medicines were put into the appropriate bin for destruction but this had not been recorded in the ledger, although the nurse had denoted 'E' on the MAR. 'E' is recorded by nurses to show if any medicine has been refused and destroyed, but nothing was shown on the back of the MAR to provide evidence of what action had been taken. The nurse did not know what the provider's policy on medicines that had been spat out was. The manager and head of care were also unable to tell us what the policy was in relation to this. This meant that staff were not aware of the policies and procedures that they needed to follow to ensure people were kept safe.

Although the action plan we received said staff would have completed training in medicines by 10 June 2015 the manager said that they could find no evidence of any certificates of training on file. The manager had not been in post in the home when the training had taken place and could not verify that the staff had been trained. As a result all nurses and senior staff, who administered medicines or creams, would attend training on 19 January 2016. This was to be provided by the company supplying the new medication dosage system in the home.

Requires improvement

Is the service well-led?

Our findings

During this focused inspection we looked at the information in the action plan received from the provider. This stated that medicines administration record (MAR) audits were completed daily. These audits were to ensure stock control of medicines and to ensure that no signatures of medicine administration had been missed. The head of care said that where gaps were found by the senior care worker the nurse who administered the medicine would sign that the medicine had been administered or refused. We checked the medication administration records (MAR) for seven people living in the home. We found that although a senior care worker checked the MARs at the end of each shift, there were several gaps and missed signatures that had not been noted. This meant that the audits were not effective to ensure people's records of administered medicines were accurate.

Although audits had been carried out which showed shortfalls had been found, it was not clear if any action had been taken to make improvements. For example the audit identified that emergency equipment was not being checked weekly but there was no action recorded to show how this was being addressed. This meant that audits were not effective in bringing about improvements.

Although the provider had processes in place to audit systems, such as medication and medication administration records, they were not well completed. This meant that the provider was not able to assess, monitor and improve the quality and safety of the service.