

DCSL Limited

Soham Lodge

Inspection report

Soham Bypass

Soham Elv

Cambridgeshire

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Date of inspection visit: 04 November 2016

Date of publication: 16 November 2016

Ratings

| Overall rating for this service | Good • |
|---------------------------------|--------|
| Is the service safe? | Good |
| Is the service well-led? | Good |

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 23 and 24 May 2016. At this inspection we found a breach of the legal requirements. This was because the provider had failed to notify the Care Quality Commission about important events that had taken place.

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 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, personal care and nursing for up to 34 people including those living with dementia or requiring mental health support. Accommodation is located over one floor, with communal areas for people and their visitors to use. There were 26 people living in the home when we inspected.

At the time of this inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

At our focused inspection on 4 November 2016, we found that the provider had followed their plan which they had told us would be completed by 30 June 2016, and legal requirements had been met.

Records showed that notifications had been submitted to the CQC in a timely manner.

Arrangements were in place to ensure that people's medications were stored, administered and disposed of safely. Records regarding the administration of people's prescribed medication were kept.

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 • |
|---|--------|
| We found that action had been taken to improve the safety of the service. | |
| People's prescribed medications were stored, administered and disposed of safely. | |
| Is the service well-led? | Good • |
| | |
| We found that action had been taken. | |
| We found that action had been taken. The Care Quality Commission had received notifications of important events in a timely way. | |



Soham Lodge

Detailed findings

Background to this inspection

We undertook a focused inspection of Soham Lodge on 4 November 2016. This inspection was undertaken to check that improvements, to meet legal requirements planned by the provider after our comprehensive inspection on 23 and 24 May 2016, had been made.

We inspected the service against two of the five questions we ask about services: is the service safe? and is the service well led? This was because the service required improvement under the question is the service safe? The service was also not meeting legal requirements in relation to the question, is it well-led?

The inspection was undertaken by one inspector. Before our inspection we reviewed the information we held about the service. This included the provider's action plan, which set out the action they would take to meet legal requirements.

During the inspection we spoke with two relatives of people living at the service, the owner, the registered manager, head of care and a registered nurse. We used observations to help us understand the care provided to people who had limited communication skills.

We looked at one care record, medication administration charts, 'as required' medication protocols and records in relation to notifications.



Is the service safe?

Our findings

At our comprehensive inspection of Soham Lodge on 23 and 24 May 2016, we found that not all staff were following the correct procedures when administering people's medication.

During this inspection on 4 November 2016 we found that the provider had made the necessary improvements.

Relatives of people living at the home said that they were happy with how their family member's medication was managed by staff. One relative said, "There has been no missed medication. The staff tell [family member] exactly what [medication] is and then pass it to him...When the meds [medication] are all given, staff then let him know the next medication time."

Arrangements were in place to ensure medication was stored safely and securely and that the medication trolleys were kept locked. Our observations during this inspection showed that people were supported by the nurse to take their prescribed medication in an unhurried, kind and patient manner. We saw that the nurse explained what the medication was for and stayed until the person had taken their medication as prescribed and in full. After each person's medication administration, we observed that the nurse washed their hands to prevent cross contamination. Accurate records of this support were kept.

We noted that medication was stored at the appropriate temperature and disposed of safely. We were told that it was only the nursing staff that administered people's medication and that they had received training to do this and had their competencies checked. Records we looked at confirmed this. We saw that there were clear instructions on pharmacy printed MARs charts for staff in respect of how and when people's medication was to be administered safely. This included those to be given 'when required.' This meant that we could be assured that people's prescribed medication was managed in a safe manner.



Is the service well-led?

Our findings

At our comprehensive inspection of Soham Lodge on 23 and 24 May 2016 we found that the provider had failed to notify the Care Quality Commission about important events that had taken place. This was a breach of Regulation 18 Registration Regulations 2009 Notifications of other incidents.

During this inspection on 4 November 2016 we found that the provider had followed the action plan that they submitted to us following our last inspection and that there was no longer a breach of legal requirements.

Relatives of people living at the home we spoke with were complimentary about the registered manager and staff. One relative said, "The staff are spot on...they keep you up to date and support [family member] 24 hours a day." Another relative told us, "The staff treat [family member] impeccably...I cannot fault the care [given]."

Since our last inspection a manager had been registered with the commission and they demonstrated that they understood their role and responsibilities. The registered manager showed us they had maintained detailed records of any untoward incidents or events within the service. There was also evidence to show that notifications had been sent to CQC when required.