DCSL Limited

Soham Lodge

Inspection report

Soham Bypass
Soham
Ely
Cambridgeshire
CB7 5WZ

Tel: 01353720775
Website: www.sohamlodge.co.uk

Date of inspection visit:
10 October 2018
15 October 2018

Date of publication:
24 December 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Soham Lodge 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 care home accommodates up to 34 people in one adapted building. At the time of the inspection there were 32 people living in the home.

There was a registered manager in place however they were not present during the inspection. 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 the previous inspection in August 2017 the home was rated as Good. However, at this inspection the rating has changed to Requires Improvement.

The quality assurance system was not effective in making sure that people received the care and support they needed in a safe way. Although audits were being completed they had not found the issues we found during the inspection. Policies and procedures were in place but these were not always being followed to ensure people were being provided with the right care and support. .

Risks had not always been identified in a timely manner so that action could be taken to reduce the likelihood of accidents or incidents. Staff had not always taken the necessary action needed to reduce risks when they were identified.

Staff had not received regular supervisions or appraisals and it was not clear what training they were expected to complete. There was no training plan to ensure staff had the knowledge they required to meet people's needs.

Information about the support people needed was not always accurate or up to date. This meant that staff were not always aware of people's needs.

Medication was not always administered or managed safely. Management had not carried out competency checks on staff to ensure they were still competent to administer medicines safely. Not all medication administration records reflected the amount of medication in stock. This meant we could not be confident that people were always receiving their medication as prescribed,

The providers recruitment policy had not always been followed to ensure new staff were only employed once two satisfactory references had been received. Other recruitment checks such as a criminal records

check had been carried out. There were sufficient numbers of staff to meet people's needs.

People were offered a choice of food and drink. People health was placed at risk because special diets were not always followed.

Although there were policies and procedures for staff to follow regarding the Mental Capacity Act 2005 these were not always being followed in practice. This meant that people were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible.

There was a complaints procedure in place. Complaints had been dealt with appropriately. However, records of the complaint, investigation and outcome had not been easy to access and were kept in various places rather than a clear record.

Staff were aware of what action to take if they thought someone had been harmed. They were aware of the internal and external reporting procedures and were confident to use them.

Staff provided care in a kind and compassionate way. They knew people well and
were aware of their history, preferences, likes and dislikes. People's privacy and dignity were respected. Staff provided end of life care and support in a way that each individual person wanted.

You can see what action we told the provider to take at the back of the full version of this report.

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 safe.

Risk assessments were not always completed in a timely manner and did not always contain information about how to reduce the risk. Staff had not always followed information in risk assessments to keep people safe.

Medicines were not always administered and managed safely.

Staff were aware of the procedures to follow if they suspected someone may have been harmed.

Is the service effective?

Requires Improvement

The service was not effective.

Staff did not receive regular supervisions or appraisals. There was not a training plan in place to ensure staff had the skills and knowledge the required to meet people's needs.

People were not always supported in the least restrictive way possible.

People did not always receive the special diets they had been assessed as needing.

Is the service caring?

Good

The service was caring

People liked the staff who were kind and caring.

People were treated with respect and staff were aware of people's likes and dislikes.

People's rights to privacy and dignity were valued

Is the service responsive?

Requires Improvement

The service was not always responsive

Care plans did not always provide guidance for staff on how to meet people's needs.

People were aware of how to make a complaint or raise any concerns.

People were supported to make decisions about their preferences for end of life care.

Is the service well-led?

Requires Improvement

The service was not well-led.

There was not an effective quality assurance process in place to identify any areas that required 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. 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.'

The inspection was prompted by a notification of an incident following which a person using the service sustained a serious injury. The information shared with CQC about the incident indicated potential concerns about the management of risk of falls. This inspection examined those risks. You will see the action we have told the provider to take at the back of this report.

This inspection took place on 10 and 15 October 2018 and was unannounced. The inspection was carried out by one inspector.

Before our inspection we reviewed the information we held about the service. We reviewed notifications the registered provider had sent us. A notification is important information about particular events that occur at the service that the provider is required by law to tell us about.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with three people who lived at the service, the deputy manager, the provider, two nurses, the head of care, and three care assistants.

We looked at the care records for six people and records that related to health and safety and quality monitoring. We looked at medication administration records (MARs). We observed how people were cared for in the communal areas.

Requires Improvement

Is the service safe?

Our findings

Risks to people's health and wellbeing were not assessed promptly and their safety was not always monitored and managed effectively.

Management and staff did not follow the provider's policy to ensure risks to people's health and welfare were assessed promptly when they moved into the home. Two people had fallen from their bed on their first night following admission. A risk assessment had not been carried out to assess for any potential risk of falling. The deputy manager confirmed that a falls risk assessment and moving and handling risk assessment should be completed within six hours of moving into the home.

Where a risk assessment was in place they did not always give staff detailed information on the steps they should take to reduce an identified risk. The providers 'Falls Management Policy and Procedure' stated that after a fall staff must "Review all risk assessments." The records showed that this procedure was not always followed after a fall.

Guidance from healthcare professionals was not always followed placing people at risk of inappropriate and unsafe care. After assessing a person with swallowing difficulties, a speech and language therapist recommended they were to have a soft diet to help reduce the risk of choking. Management and staff had revised their care plan to include relevant guidance for staff however kitchen staff had not been informed of changes. A notice in the kitchen stated the person was to have regular snacks of toast and biscuits. Staff had not followed the care plan and recorded in the daily records on two occasions, during the last two weeks, this person had eaten biscuits. Staff confirmed the person would not have understood the risk they were taking to their health by eating the biscuit.

Medication was not always administered and managed safely. Staff were required to complete a competency assessment annually to ensure that they had the required skills and knowledge to administer medication in a safe way. Three of the six staff records we looked at showed that their medication competency had not been completed in the previous year.

We checked that the stock of medication tallied with the medication administration records. Three out of 12 records did not reflect the amount of medication in stock. This meant we could not be sure that the medication had been administered as prescribed.

On the first day of the inspection not all medication to be taken "when needed" (PRN) had protocols in place to explain when it should be administered. The records showed that some of these medications had been administered. We discussed this with the deputy manager and the protocols had been completed by the second day of the inspection to ensure that the medication was administered in a consistent way.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

The provider's recruitment policy was not always followed and therefore the provider could not be assured new staff recruited were suitable for the role. Not all required pre-employment checks were undertaken before new staff commenced employment.

Policies and procedures were in place to support staff in the event of a person having an unforeseen accident or incident. There were systems in place including an electronic data analysis system to check accidents and incidents records for any patterns or trends. Accident forms were completed by the member of staff working with the person and would be reviewed by the registered manager.

People told us that they felt safe. One person told us, "Yes I feel safe, the staff are here when I need them."

Staff demonstrated a good understanding of how to safeguard people, recognise signs of harm and what to do if they had concerns. One staff member stated, "I would talk to the deputy or manager(registered) If I saw something I didn't like." Staff told us and the records confirmed that they had completed initial training in safeguarding people from harm. However not all staff had completed refresher training to ensure their knowledge was up to date.

There were sufficient numbers of staff to keep people safe. Staff told us they had adequate time to assist people with activities such as personal care, administration of medication and assistance with eating and drinking. They stated that when staff took unplanned absence then it was not always possible to get cover at short notice and this meant that people had to wait longer to be assisted with any care. The deputy manager stated staffing levels were based on dependency levels of people living in the home. They confirmed that if extra staff were needed, such as supporting people at the end of their life, then this was organised.

There was an infection prevention and control policy and statement in place. Infection control audits were carried out. Staff had completed training in prevention and control of infections. Staff confirmed that personal protective equipment such as gloves and aprons was readily available and used when assisting people with personal care.

Contingency plans were in place so that the service could continue in the event of any emergencies. For instance, a flood or fire. Regular checks of the fire alarm system had been carried out.

Requires Improvement

Is the service effective?

Our findings

Management had not provided staff with regular support, supervision and training to deliver effective care and support in line with best practice guidance. Formal supervision and appraisal had lapsed and staff had not received regular support in their day to day practice or been given the opportunity to discuss performance, development and training needs. The on-going monitoring and assessment of staff helps to ensure care delivered to people is appropriate and safe. Staff said they could speak to their line managers if they needed support with any issues.

It was not clear from the training records or from talking to staff what training courses they were expected to complete or when they should complete refresher training. Some staff had completed training within the last year including end of life care, fire safety, moving and positioning people, food safety, dementia and the prevention and control of infection.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

New staff induction training included the Care Certificate. The Care Certificate identifies a set of care standards and introductory skills that health and social care workers should consistently adhere to and includes assessments of competence. Staff confirmed induction also included mentoring from an experienced staff member before being signed off as competent to work on their own by a senior member of staff.

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 in their best interests and as least restrictive as possible.

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. In care homes this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and we found they were not. Staff had completed training on the MCA and there were policies and procedures in place to support staff to follow the guidelines of the MCA. However, management and staff did not have a good understanding of the MCA principles, and they were not followed. Despite a person having capacity to make a decision about their personal care, it was stated in their care plan for staff to assist them with personal care even if they told them not to. Another person had the capacity to make a decision about their alcohol intake but staff were restricting their intake at the request of their family member. Whilst the person accepted their permitted one glass, staff told us they did not know what action to take if they requested more.

We observed people's lunchtime experience and saw that people received the help and support they needed with eating and drinking. People were given a choice of main meals and deserts. People told us that they liked the food and that there was always enough to eat and drink. One person told us that they enjoyed it when their family member paid for a meal and joined them.

People had access to several communal areas of the home. There was also an outside seating area that had been used in the warmer weather. The provider employed a full time maintenance man who ensured that the building was safe for people and their visitors and staff.
Records showed that when people needed to see a doctor or other healthcare professional this was always organised for them in a timely manner. People told us and records showed they were supported to access healthcare professionals for any issues. The local GP visited each Monday and, if needed at other times. During the inspection we saw that staff carried out basic health checks for people who were unwell so that they had the information to give to the doctor when they visited later that day.

Good

Is the service caring?

Our findings

People said that staff worked hard and were kind, caring and respectful to them

During the inspection we saw lots of positive interaction with people. We saw that staff respected people's personalities by approaching them in a way that suited them. For example, we saw that some people liked to hug the staff whilst others needed staff to give them space and listen to what they were trying to say.

Staff were observed knocking on bedroom doors before entering and ensuring that bathroom doors were closed before assisting people with personal care. Personal information about people was held securely so that it was only accessible to staff or visiting healthcare professionals as required.

Staff told us how they tried to encourage people to make choices. For example, they offered choice with food and drinks and asked what clothes people would like to wear. We saw during the inspection that staff understood people's communication needs and knew they might not understand when something was being offered verbally and showed them prompts. For example, the activities coordinator was encouraging people to help make shortbread. When people did not understand the request the activities coordinator showed them the bowl and ingredients.

People living at Soham Lodge and their relatives were invited to attend meetings so that they could share their views on how the home was run.

The staff told us that visitors were always offered drinks and were welcome to stay for meals with the family members. Relatives were also invited in to share special occasions with their family members such as birthdays and Christmas.

Relatives had sent many cards of thanks to the home for the care their family members had received whilst living at Soham Lodge. One relative had commented, "Thank you for all the care and kindness you all showed my [family member] on their two-week respite break, what a lovely and safe place." Another relative had said, "[Family member] was well looked after and their needs were being met."

Requires Improvement

Is the service responsive?

Our findings

Staff showed an understanding of people's needs and were able to tell us about the support they needed with any health issues and what action they would take if they had any concerns. However, there was no consistent and planned approach. People's care plans were not always up to date and staff were not routinely referring to them. This put people at risk of receiving care that was not current and inconsistent. For example, one person's care plan said that they were prone to losing weight and should be weighed weekly but weekly weights were not recorded. However, the weight records for the person showed that they had not been weighed weekly. The deputy manager stated that the person did not require weekly weighing as they had gained weight.

Care plans contained detailed information about what physical conditions staff should check if a person was displaying signs of anxiety and distress. For example, staff were told to check that the person had sufficient fluid intake. Staff were able to tell us what action they would take to ensure individuals and others around them were safe. However, there was a lack of clear guidance and key information for staff to enable them to consistently deliver the right support to people with their emotional and mental health related needs. Some plans of care were vague in relation to the triggers, understanding and personalised support needed by people who at times presented distressed behaviour or behaviour that was challenging to others.

We recommend the service seek advice, guidance and training from a reputable source, about effective person-centred care planning.

The service used assistive technology to support people to receive care and support that was responsive to their needs. For people at risk of falling, motion detectors were used to alert staff they were moving about and staff respond immediately. The service had purchased mains powered turning beds which turned a person from side to side to assist with pressure relief and reduce the risk of pressure acquired ulcers.

People were supported and encouraged to spend their time taking part in activities and events that interested them. People told us that there were various activities they could join in or attend such as cookery, quizzes, reminiscing, dominoes, board games, and musical entertainers brought into the home. Two people told us that they would like to have trips out of the home arranged. The deputy manager told us this was being arranged. As well as group activities staff were seen taking part in one to one activities with people.

A complaints procedure was in place and being followed. Not all information regarding complaints, the investigation or the outcome was easy to access. However, action had been taken to investigate complaints and appropriate action had been taken in response to the findings.

The gold standards Framework (GSF) ensures that staff provide a gold standard of care for people nearing the end of life. Soham Lodge had recently been reassessed for the Gold Standards Framework(GSF) and had been commended for the care and support they showed people at the end of their life. One member of staff

told us, "We listen to the person and focus on them to find out what they want." Another member of staff told us, "We make people's last days happy and show them respect and dignity."

Requires Improvement

Is the service well-led?

Our findings

At this inspection we found shortfalls in the management and oversight of the service which meant the service had failed to sustain a good rating. The provider and management had not independently identified issues we found during the inspection or breaches in regulation. Quality monitoring systems were failing to continuously assess the quality of the service, drive improvement or find where lapses had occurred. For example, care plans were being regularly audited however the audits had not found a person was not receiving the care and support their care plan said they should be or that risk assessments were not completed promptly. Daily reports were completed for people about their daily care even though they were in hospital at the time.

The absence of effective monitoring or auditing meant that issues related to people's care and support were missed and risks of potential harm were not being mitigated as far as possible.

Management and staff were not following the providers recruitment policies and procedure.

Action had not been taken to ensure that staff received regular supervisions, appraisals or completed all their training as required.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Providers of health and social care are required to inform the CQC of certain events that happen in or affect the service. The provider had informed CQC of the majority of significant events. However, they had failed to notify the CQC of one serious injury. The deputy manager stated that they were waiting until they had received all of the information about the person's injury from the hospital. There were clear records showing if any safeguarding allegations had been raised, they were reported to the appropriate safeguarding authorities and the Commission, including the outcome of any investigation.

There was a registered manager in place at the time of the inspection. The registered manager was not present during the inspection. The provider stated that action had been taken to strengthen the management team of the home so that any areas for improvements could be identified in a timely manner and the necessary changes made.

Staff members' individual skills were recognised and some had been appointed as champions in areas such as dignity and dementia. The champions completed extra training when applicable and used this knowledge to make improvements in the home. For example, one member of staff told us that they were the dementia champion and they had used their training and knowledge to ensure that people living with dementia had plates that were easier to see than the normal white plates. Staff members confirmed that they attended team meetings and that they could add items to the agenda if they had anything to raise. However not general staff meetings had been held since February 2018.

Staff understood the term 'whistleblowing'. This is a process for staff to raise concerns about anything in the workplace. The provider had a policy in place to support people who wished to raise concerns in this way. People could be assured that if ever poor care was ever identified that it would be dealt with appropriately and that appropriate action could then be taken.

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 People did not always receive safe care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems to assess monitor and improve the quality of the service were not effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always receiving sufficient training, supervisions and appraisals.