Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Soham Lodge

Qua Fen Common, Soham, Ely, CB7 5DF

Tel: 01353720775

Date of Inspections: 28 November 2012
26 November 2012

Date of Publication: January 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✖	Enforcement action taken
Safeguarding people who use services from abuse	✓	Met this standard
Management of medicines	✖	Enforcement action taken
Requirements relating to workers	✖	Action needed
Staffing	✖	Action needed
Supporting workers	✓	Met this standard
Complaints	✓	Met this standard
Records	✖	Action needed

Details about this location

Registered Provider	DCSL Limited
Registered Manager	Ms. Jacqueline Doyle
Overview of the service	Soham Lodge is a nursing home for up to 26 people. Because of the areas needed for improvement the provider has voluntarily placed a ban on new admissions to the home until they feel that there has been sufficient improvement.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 26 November 2012 and 28 November 2012, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

We talked with five people who were living in the home. They all told us that there were not enough staff on each shift to meet people's needs. One person told us, "When it's busy I don't always get turned." This related to prevention of pressure sores. They also told us that the staff treated them with respect and were kind to them and said that, "The girls are lovely". Another person told us, "The care is lovely, really good" and "They try and do as much as they can but sometimes it's not possible as there are not enough staff". All of the people that we talked with stated that they had not seen their care plan or been offered the opportunity to do so.

One person told us about an event that had made them feel unsafe and how the staff had taken appropriate actions so that it would not happen again. We found that care plans did not all accurately reflect people's needs and that not all treatment provided by the nurses had been recorded. There were discrepancies between the medication administration records and the stock levels of medication. Staff were aware of what process they should follow if they thought someone had been abused. Recruitment procedures were not always followed to ensure that the right people were employed. The provider told us what they thought the minimum staffing levels should be but these had not always been maintained. Staff had received mandatory training and supervision.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 19 January 2013, setting out the action

they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against Soham Lodge to protect the health, safety and welfare of people using this service.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Enforcement action taken

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People did not experience care, treatment and support that met their needs and protected their rights.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

Before people had moved into the home the manager had met with them to assess their needs. Risk assessments had been completed, however, the risks that they highlighted were not always followed up with a comprehensive care plan. The care plans had been completed and were available on the computer at the nurses station. Only people who had completed the computer training could access the care plans. The care plans had been printed and put into folders but it was not clear if they were the most recent version of the care plans. Nurses were responsible for the writing of the care plans, however, all four of the nurses that we talked with told us that they did not have enough time to complete the care plans or ensure that they were up to date.

We looked at the care records for one person who was in the home to receive palliative care. Their goals were to maintain their dignity, optimise their pain management and promote a calm, peaceful and pain free environment. However, their care plan contained no instructions for staff about how the care should be delivered, in order to meet the person's needs in relation to palliative care. The section titled interventions did not contain any information. The care plan also stated that the person would have either a bath or shower every morning. However, the nurse in charge of the shift when we visited and the person the care plan related to told us that they were on complete bed rest due to the development of pressure ulcers. Failure to update care plans when people's needs change could place their health at risk.

The care records for the same person showed that they had a grade four pressure sore. The care plan stated it should be "dressed as needed". However, the nurse in charge of care on the day of the inspection stated that it should be dressed at least twice a day. The person whose care plan it was also told us that the tissue viability nurse had told them that the pressure ulcer should be dressed at least twice a day. The care records also stated, "A

photograph will be taken once a week to monitor the progress of the ulcers. The wound will also be measured once a week". We asked to see the photographs and measurements but were told by the nurse in charge of the shift and the manager that no photographs or measurements had been taken since the initial assessment on 5 November 2012. Failure to monitor any changes in the pressure ulcer could prevent the right treatment being administered. The care records also stated that, "A wound chart will be completed for each ulcer when the dressing is changed." We asked to see the wounds charts for November 2012. The only wound charts that had been completed were three for 10 November 2012 and one for 20 November 2012.

The care records for the same person stated that they should be repositioned every two hours and that this should be recorded. We asked to see the turn charts for person A for the previous week. On 21 November the turn charts showed that person A was turned at 10.30hrs and not again until 13.30hrs and then not until 16.00hrs. On the 22 November 2012 there was no record of any turns between 11.00hrs and 18.00hrs and then not again until 23.00hrs. We could not find any records for the 24 November 2012. We asked the manager if they thought Person A was being turned but it was not being recorded and they started they could not be sure if it was a recording issue. We asked Person A if they were turned at two hourly intervals and they told us that, "It depended how busy the staff were." They stated that, "If staff are busy I don't get turned two hourly." The lack of regular repositioning could be a contributory factor in the development of this person's pressure sores.

We looked at the care records for a person who had type 2 diabetes. We asked to see their care plan for how this should be managed on two occasions during our inspection. We were not given a care plan relating to diabetes and could not find one in the care records that we were shown. Failure to provide information about how a person's diabetes should be managed could place the person's health and safety at risk.

Two care assistants told us that they had never seen a care plan since working at the home. The manager and provider both confirmed that the care plans were not comprehensive and did not give staff all of the information they required to meet people's needs. The provider stated that they had chosen not to admit any more people into the home until they could ensure their needs could be met. They also stated that an extra nurse had been provided on some shifts to enable more time to be spent on improving the care plans. We talked with three people living in the home and they all told us that they had not seen their care plans or been offered the opportunity to look at them.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

The manager stated that the home followed the local authority procedures when dealing with any safeguarding issues. All of the staff that we talked with were aware of the procedures to follow if they suspected anyone had suffered any kind of abuse. Although the contact numbers for the local safeguarding team were displayed in the home some of the staff did not know where to find them. The manager stated that staff completed both in house safeguarding training and also attended local authority safeguarding training when places became available.

Management of medicines ✖ Enforcement action taken

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

We looked at the medication administration records for five people. We found that three people were prescribed alendronic acid. We asked two nurses who were responsible for administering medicines if any special precautions should be taken when administering alendronic acid. The nurses stated that they were not aware of any special precautions that should be taken. We asked if the alendronic acid was administered at the same time as other oral medicines and food and were told that it was. The British National Formulary for alendronic acid states, "Tablets should be swallowed whole with plenty of water while sitting or standing; to be taken on an empty stomach at least 30 minutes before breakfast (or another oral medicine); patient should stand or sit upright for at least 30 minutes after taking it". This information was also available in the information leaflet supplied with the medicine. The fact that staff were not following the specified instructions for administration could reduce the effectiveness of the medicine.

The medication administration records for three people showed that there were discrepancies between the amount of tablets received, the number of signatures to show a tablet had been administered and the number of tablets left in stock. In addition we found the home did not monitor medicines in a way that would have enabled such errors to be identified.

We noted that there was a lack of information available on the management of people's medicines. We talked with the nurse who was responsible for administering medication on the 28 November 2012. They confirmed that there was one person who was prescribed a sedative for periods of agitation as and when required. We asked to see the protocol that should be followed so that the nurse would know when to administer the medication. They stated that there was no protocol in place and it would be administered at the nurses' discretion. This could result in a lack of consistency in the administration of this medicine.

We also asked if care staff had access to information about what medication people were prescribed and the possible side effects that they should be aware of. The nurse confirmed

that this information was not available to the care assistants. We talked to one person about their pain management. They told us that their pain was bearable as long as they received their pain relieving medicines on time. They also told us that on the 24 November 2012 they had received their morning medication three hours late which had resulted in them being in pain. Their care plan for medication stated "my medication will be given at the prescribed times." We talked with two nurses who told us that the medication round could take up to two hours to complete each time so people were not always receiving their medication at the right time.

Requirements relating to workers ✖ Action needed

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was not meeting this standard.

Robust recruitment procedures had not been followed to ensure that people were cared for, or supported by, suitably qualified, skilled and experienced staff.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We looked at the recruitment records for three members of staff. The records showed that application forms had been completed and interviews had taken place. The provider had carried out checks to ensure that the nurses that had been employed were registered with the appropriate professional organisation. The provider had requested references and criminal records checks. Although references had been received they had not been verified with the person providing them. Not all of the forms used during the recruitment procedures had been completed fully. For example, in one staff record we looked at, their interview form did not have a name on it, the information about their professional registration had not been completed on their application form and their fitness to practice section of their application form had not been completed. They had not given the reasons for leaving their most recent employment or the date their employment ended. These examples demonstrated that current procedures for recruitment were not sufficiently robust to protect people from the risk of unsuitable staff.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people's needs at all times.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Over the two days we carried out the inspection we spoke with the manager and four nurses. All of them told us that there was normally only one nurse on each shift and that this had not been sufficient to meet the needs of the people living in the home. We asked the provider and manager how they determined how many nurses and care staff were needed on each shift. The provider told us that they did not use any formal assessment tools but just asked the staff what the needs of the people were currently living in the home.

The provider told us that in their opinion they needed one nurse on each shift plus at least seven care staff on the morning shift, six care staff on the afternoon shift and three care staff during the night shift. They also said that a second nurse was on duty during the day shift for 7 days in October and 17 days in November and that a clinical nurse manager was available 5 days a week to support the nursing staff. However due to sickness and the need to recruit more staff these minimum staffing levels were not always maintained. We asked to look at the rotas for the previous four weeks so that we could see how many staff had been on duty on each shift. However, the rotas could not be found. We looked at the current rota and found that on Saturday 24 November there were only four care staff on the afternoon/evening shift. On Sunday 26 November there were only four care staff on the morning shift and five care staff on the afternoon shift. We saw that the rota for Friday 30 November did not include any care staff for the afternoon/evening shift. Neither the provider or the manager were aware of this.

On Saturday 24 November the nurse on duty had been from an agency. This had resulted in the medication round taking longer and one person receiving their medication three hours late.The provider told us that they had provided an extra nurse on some shifts to allow the nurses to update the care plans. One nurse told us they had resigned because there was not enough time with only one nurse on shift to do a "…good job". Another nurse told us that staff sometimes went without breaks so that they could get people up in the mornings in a timely manner. One person who was visiting a relative that lived in the home told us that they and another relative had to make lunch for people on one occasion after people had been left waiting for an hour and half for their lunch due to the home

being short staffed.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

The records showed that the care staff were receiving regular supervision. The care staff told us that they had received an induction and mandatory training. The records showed that staff had received training on: The role of the health and social care worker, infection control, dementia awareness, moving and handling, communication, person centred support, the Mental Capacity Act, safeguarding vulnerable adults from abuse, fire safety, first aid, computer training to enable them to access the care plan system and health and safety. The provider may find it useful to note that although there was a chart summarising the training so that the manager could monitor the staff training needs, not all staff had been included on the chart. The manager stated that training was also being booked for specialist areas such as the prevention and management of pressure sores.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available.Comments and complaints people made were responded to appropriately

Reasons for our judgement

The manager stated that no formal complaints had been received directly by the home since they had started working there, they stated that they were aware of one complaint that had been made to the Commission. They confirmed that they would be investigating it and responding as appropriate. The details of who people should complain to if they were not happy with any aspect of the care being provided was on display in the entrance area of the home. The staff that we talked with told us that they would refer any complaints to the manager.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

During our inspection we asked to see the staff rotas for the previous four weeks. Only the current rota could be found. It was not clear which bank staff or agency staff had worked in the home. The manager contacted the member of staff who was responsible for the planning of the rotas but the rotas still could not be found. This meant that it was difficult for the registered person to assess whether staffing levels were sufficient to meet people's needs. Care plans did not always reflect people's current needs and there were records missing for the dressing of people's wounds.This meant that the registered person could not always monitor whether people's needs were being met at all times.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010** **Requirements relating to workers**
	How the regulation was not being met: The registered person has not operated effecive recruitment procedures to ensure the right people are employed. Regulation 21.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: The registered person has not ensured that at all times there are sufficient number of suitably qualified, skilled and experienced person employed to safeguard the health, safety and welfare of people. Regulation 22.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**

This section is primarily information for the provider

care Treatment of disease, disorder or injury	**How the regulation was not being met:** There were not accurate records in respect of each person relation to their care and treatment. Records could not be located promptly in relation to the management of the regulated activity. Regulation 20.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 19 January 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 15 January 2013 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
Treatment of disease, disorder or injury	**How the regulation was not being met:** The registered person had not taken proper steps to ensure that each service user was protected agains the risk of receiving care ot tretament that was inappropiate or unsafe. Regulation 9.
We have served a warning notice to be met by 01 January 2013 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
Treatment of disease, disorder or injury	**How the regulation was not being met:** The registered person had not made appropiate arrangements for recording and safe administration of medicines.

This section is primarily information for the provider

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk