# 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 Inspection: 24 February 2014

Date of Publication: April 2014

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

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| **Care and welfare of people who use services** | ✓ Met this standard |
| **Cooperating with other providers** | ✓ Met this standard |
| **Assessing and monitoring the quality of service provision** | ✓ Met this standard |

## Details about this location

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| Registered Provider | DCSL Limited |
| Registered Manager | Mrs Shirley Anne Love |
| Overview of the service | Soham Lodge is a nursing home for up to 26 people. Some of the people who use the service are living with dementia. |
| Type of service | Care home service with nursing |
| Regulated activities | Accommodation for persons who require nursing or personal care<br>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 inspection was part of a themed inspection programme specifically looking at the quality of care provided to support people living with dementia to maintain their physical and mental health and wellbeing. The programme looked at how providers worked together to provide care and at people's experiences of moving between care homes and hospital.

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 24 February 2014, 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, talked with staff and received feedback from people using comment cards. We were accompanied by a specialist advisor.

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.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

### What people told us and what we found

During our inspection we looked at how people were cared for and how staff supported people living with dementia. We spoke with the registered manager, the activities co-ordinator, one staff member , four people who used the service living with dementia and eight relatives visiting on the day of our inspection. We also received 10 comment cards from relatives of people who used the service. All the comments we received were complimentary about the service and its staff.

We found that staff were caring and attentive to people's needs. We saw that people had enough to eat and had access to snacks throughout the day. The service had a dedicated activities co-ordinator that worked with people and their relatives to deliver tailored activities on an individual basis and in groups.

We saw that the service had effective working relationships with other providers and accessed other professionals to support people when this was required. The registered manager told us that the hospitals worked well with them to support people who were being admitted or being discharged.

We saw that the service had effective quality assurance processes in place to monitor the dementia care people received.

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

## 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** ✓ Met this standard

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

### Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

### Reasons for our judgement

How are the needs of people with dementia assessed?

We looked at the care records of two people with dementia. We saw that people had an assessment of their needs completed before they were admitted to the service. The service completed these assessments with people and their families to ensure that it was person centred. The assessment included the identification of people's mobility (including falls and manual handling), nutrition, behaviour and their mental health. The service also used reports from social services and inpatient discharge summaries to inform their assessments. This meant that the provider completed a thorough assessment to ensure they could meet people's individual needs.

The GP visited in a new person's first week to review their medications, the pharmacist worked closely with the practice and had oversight of the people's medication regimes. This meant that people's medical health needs were assessed and reviewed at admission to ensure their safety and wellbeing. The service also worked with the local mental health team to ensure that people's care is asssessed based on their diagnosed dementia needs.

We saw that people's care records after admission were regularly reviewed. We saw that care plans were detailed for all areas of people's personal and health needs. The information in people's care plans was based on the information gained during assessment.

How is the care of people with dementia planned?

We found that where people had identified needs, care plans were in place that detailed steps that should be taken to meet these. The provider worked with the mental health team and GP to ensure that care for people with dementia was planned based on their needs and where possible with their involvement and their family's input. The use of life histories which included details of past achievements and interest were incorporated in the planning of people's care. For example, one file we reviewed included a detailed life

history with photos and newspaper cuttings of significant events. The family also had a copy and were very pleased to have been involved with their relative and the service in completing the work. One comment we received stated, 'They have care plans in place written by nurses that have been expressed by relatives about things the resident likes/dislikes and their needs. So all health professionals can read to understand.'

Care was planned in a way that ensured that all aspects of people's daily living and wellbeing was being supported. The care plans contained standardised assessments which related to people's health needs for example they assessed people's risk of falls and risk of malnutrition. Assessments were evaluated on a monthly basis and identified the change in risk.

People's care plans contained risk assessments around their needs such as mobility, skin care, risk of falls and nutritional and emotional support. These were regularly reviewed and changed as required.

Are people with dementia involved in making decisions about their care?

People we spoke with were able to exercise some choices around their basic needs for example what they would like to wear, what they chose to eat and when they chose to rise and go to bed. The two staff that we spoke with demonstrated an understanding of supporting people with dementia to participate in decision making. The activities co-ordinator told us how they supported people with dementia to partake in activities on a one to one basis and in a group.

We observed staff providing people with choices but the provider might find it useful to note that these were often presented too far in advance, for example, people were asked their choices for lunch in the morning, but we observed that by lunch time they had forgotten what they had ordered or no longer wanted their choice from the morning. Staff did not remind people again and did not offer alternatives when people did not eat their first choice. The manager told us that the staff knew people well and this might have been the reason they were not again reminded of their choices. However stated that they would introduce the pictorial menus already in use for people to make their choices earlier in the day at lunch times as well to remind people of their earlier choices and provide them with an opportunity to change these choices if needed.

We observed the registered manager speaking to people on the day of our inspection. Relatives of people who used the service had a meeting with the manager and activities co-ordinator during our inspection about the service's Easter event and planning for the event. They were all very complimentary about the service. This meant that people had access to the office team and management.

The care records included a Priorities of care document and advanced care plan detailing wishes at end of life.

The registered manager explained that if a person lacked capacity to make an informed choice about a decision relating to their health and wellbeing they worked with the person's family, other professionals and the person wherever possible to make a best interest decision on their behalf.

Are people with dementia provided with information about their care?

Records that we looked at confirmed that people who used the service and their families

were involved in the review of their care. Where people were able to they signed their care records to show that they had been involved in their care planning.

We observed staff giving people choices and information about their daily routines. The people we spoke with told us that they were involved in decisions about activities and meals.

Keyworkers were identified outside people's rooms along with their named nurse. These did not contain photos of the relevant taff member which might mean that people did not know who their key worker was as they were unable to identify them visually. The provider told us that they were waiting for a notice board that had been ordered on which they will display staff photographs safely.

There was information available at the service reception for people to access. The service involved people and their families in the service and planning of events and fundraising. People were complimentary about the way the service involved them. One comment received said, 'We are always made welcome when we come to visit.' Another person wrote, 'It seems like one big happy family. Special occasions are remembered. Involving residents every day with activities (also with visitors).' Another person wrote, 'They (staff) are all a great support to myself (relative) and family as well as (name of person who used the service).'

There are lots of information boards and signs about the home stating what each room is for, people's rooms have their names and that of their keyworker displayed with the residents photograph.

The provider might find it useful to note that information could be improved for people with dementia by having communication aids such as menus with photographs of the meal choices on the table at lunch time. Although these were provided for the purposes of choosing meals earlier in the day people forgot what they had chosen by lunch time.

How is care delivered to people with dementia?

Care was delivered in a person centred way with staff having a good knowledge of the people's usual routines and habits. There was on-going work to create memory boxes for people who might benefit from them, one person had a memory box they regularly used and this had helped with them. The person's relative noticed that the box helped their recognition of people and objects.

The majority of care staff engaged the people in incidental conversation and offered information about what was happening and included people in wider conversations. Staff were respectful and kind at all times. People told us that they felt, "safe and warm." Another person we spoke with said "I can't find fault with it." A further person said, "I couldn't wish for better." Comments received from the cards people completed gave feedback that, '(Name) receives high quality care by the friendly professional carers.' Another person wrote, 'The care given to my (relative) at the lodge is the best we could ever wish for.'

We spent some time in one of the lounges on the unit. Using SOFI we observed staff supporting people to access all areas of the service freely. People were relaxed and walked around the service confidently. Overall staff were patient and attentive, explaining everything to the people and waiting for them to respond before continuing to support them.

Is the privacy and dignity of people with dementia respected?

Staff demonstrated kindness and understanding when they supported people with dementia. Privacy was respected by people knocking on people's bedroom doors and people's preferred names were used. Relatives told us that there were good levels of dignity and they felt that people were always dressed in co-ordinating outfits and hair and nails were tended to.

The use of life stories and memories boxes promoted engagement with staff and people and ensured dignity and individuality was promoted. One relative wrote on the comment card returned to us, 'Everyone in this home is treated with the respect they all deserve. Carers are often seen holding hands with residents to calm them down and reassure them.'

**Cooperating with other providers** ✓ Met this standard

**People should get safe and coordinated care when they move between different services**

## Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

## Reasons for our judgement

How does the provider work with others when providing care to people with dementia?

The registered manager informed us that they always received information from social services about people before they came to live at the service and that they always completed a full assessment of people's needs before admission. Two care plans we reviewed confirmed this. We asked the provider about their relationship with local hospitals. They explained that overall they worked well with the local hospitals and had effective discharge planning agreements in place. The provider followed an agreed discharge plan with discharging hospitals for the admission of new people to service to ensure that discharges occurred in a safe and agreed timeframe. This meant that the provider worked with other providers to strengthen joined working to ensure safe care.

When people were admitted to hospital they had information sheets about who they are and their needs as well as medication records that went with them to hospital to enable hospital staff to support people safely and effectively.

Are people with dementia able to obtain appropriate health and social care support?

The records show good involvement with the multidisciplinary teams such as occupational therapists (OT) and dietitians. People received regular visits from chiropody, OT, physiotherapists, dentist, dietitians and their GP. Changes in the people's wellbeing was recorded and these were used to trigger external referrals. For example one person's weight loss over a period of two weeks prompted a referral to dietetics and later the speech and language therapy team.

Relatives we spoke with felt included in all external referral decisions and were invited to be present for visiting professionals if appropriate.

Relevant information was sent with people when they are admitted to hospital, including medication charts, next of kin details, usual presentation and the Do Not Attempt cardio pulmonary Resuscitation (DNAR) form if applicable.

DNAR records evidenced discussions with family, staff and the GP. The records were fully completed, signed and dated.

The provider worked with the local surgery and a visiting GP ran a weekly surgery at the service. This had reduced unnecessary call outs. We spoke with the GP during their visit. They felt staff were alert to changes in people's wellbeing and made appropriate referrals. The nursing team worked well with the GP and together they agreed treatment plans which ensured that people received safe and co-ordinated care. Records were kept of all actions taken during the GP's weekly visits.

The GP described  issues with accessing wheelchair services which were provided through an external contract. The registered manager spoke with us about these difficulties and described how they had continued to work with the service to improve communication which improved the service delivery of wheelchairs to people who used the service. This showed us that the service continued to work on relationships with other providers to ensure good service delivery for people who used the service.

**Assessing and monitoring the quality of service provision** ✓ Met this standard

**The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care**

## Our judgement

The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

## Reasons for our judgement

How is the quality of dementia care monitored?

We spoke with the registered manager about quality assurance and how this is used to support and improve services for people living with dementia. They monitored the quality of dementia care through regular structured team meetings, clinical meetings and staff supervision. We saw from training records that staff had completed training in dementia awareness. Staff also received training in pressure care, safeguarding of vulnerable adults, personal development, depression, the Mental Capacity Act and the Skills for Care common induction standards. These are standards of care recognised as good modules of training for care staff to gain a basic understanding of their role and care requirements.

The service told us that they were not signed up to the Dementia pledge. The Dementia Pledge means that a care provider pledges to work towards demonstrating that they can meet the principles of the pledge. They told us that they worked closely with the local mental health team and had a mental health and dementia training champion in the service who worked with all staff to ensure good dementia care practices.

One person commented, 'The management is excellent with ensuring the standards are met.'

How are the risks and benefits to people with dementia receiving care managed?

We found recorded evidence of a number of tools used to monitor the quality of service people received. For example, accidents and incidents were recorded and each report showed actions taken to avoid reoccurrences. The clinical team also met regularly to review trends in accidents and incidents to take further action if required to improve practices and safety. The service completed regular safety checks of the premises such as fire alarms, electrical testing, gas safety and hoist and bed safety checks.

We found that the service was clean and hygienic throughout. The service had wide, well lit corridors and people were complimentary about the environment their relatives lived in. One person commented, 'The place is always clean and smells fresh.' Another person

commented, 'The home is beautifully kept, clean and warm with care.'

The registered manager told us that the service had an experienced training lead who worked alongside the registered manager and trained nurses to identify and provide robust training for staff. Further training such as literary competency, national vocational qualifications in health and social care and courses for mouth care, vital signs for senior care workers, spinal care and eye and ear care training had also been arranged.

The registered manager explained that after a recent review of staffing levels and support requirements they had commenced interviews internally for senior care support workers. These senior staff members would be responsible for supporting the clinical staff with documentation related duties and ensuring effective care delivery on duty. This showed us that the provider worked continually to improve the quality of the service provided to people.

Care plans were reviewed every four weeks by the nursing staff. Care staff and the activity co-ordinator contributed through comprehensive daily logs. Notes from relatives and requests for information were filed in people's care plans.

We observed that there were enough trained and qualified staff on duty throughout our inspection to provide people with safe and effective care. They were also able to engage people in meaningful activities such as reminiscence sessions, music therapy and one to one activities that people enjoyed. We spoke with the activities co-ordinator who told us that they engaged people on a one-one and group basis. Activities included cookery, gardening, bingo,scrabble, arm chair exercises and outings around the area.

Are the views of people with dementia taken into account?

On the day of our inspection the service was having a meeting with relatives to discuss up and coming events at the service. Eight relatives attended this meeting and told us that they were always involved in the activities at the service, that their views were sought and that they felt their relatives were treated with dignity and their choices respected. The service held regular relatives meetings and reviews with people and their families if appropriate to review their care needs and goals. People commented that they felt involved and were able to express their views. One person commented, 'The staff are so helpful, they listen, show care and attention and always strive to help no matter. I want to move in myself.' Another person commented, 'This is where all care homes should set their standards.' Another person commented, 'Relatives are fully involved. Residents are put at the heart of the service.'

We observed staff responding to people's views and wishes. Care plans reflect individual preferences. Care plans showed evidence that people were included in care planning activities such as life story work. One relative told us that the story work that had been completed had added great value to their relatives life and allowed them to engage more easily in conversation.

We saw in records and observed during our inspection that people's views regarding activities of daily living including where and when they would like to eat were accommodated.

Consent for care activities was always sought by care staff and activity co-ordinator.

## 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 other services less often. 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.

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.

| | |
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| ✓ **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.<br>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.<br>We monitor the implementation of action plans in these reports and, if necessary, take further action.<br>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. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). 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:

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| 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

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