Inspection Report

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

Foxley Lodge Residential Care Home

24-26 Foxley Hill Road, Purley, CR8 2HB

Tel: 02086684135

Date of Inspection: 23 November 2012

Date of Publication: January 2013

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

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Meeting nutritional needs	✓ Met this standard
Safeguarding people who use services from abuse	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	Foxley Lodge Residential Care Home
Registered Managers	Mr. Yogindranath Abhee Mrs. Josephine Militante
Overview of the service	Foxley Lodge provides residential care for up to 22 people who have dementia.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

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 reviewed all the information we have gathered about Foxley Lodge Residential Care Home, looked at the personal care or treatment records of people who use the service, carried out a visit on 23 November 2012 and observed how people were being cared for. We checked how people were cared for at each stage of their treatment and care, talked with people who use the service, talked with carers and / or family members and talked with staff. We talked with stakeholders.

What people told us and what we found

At the time of our visit there were 22 people using the service. We spoke with six people and three visitors. We also spoke with six members of staff, the registered manager and the registered provider's wife.
The majority of people living at Foxley Lodge do not have the capacity to fully share their views regarding their care. In order to make judgements about people's care experiences, we observed care practices; interactions with staff and tracked six people's records of care. Case tracking means we looked in detail at the care people receive.
Staff respected people's routines and preferences and ensured their dignity when providing personal care. People we spoke to commented that they found the staff to be "kind" and "always cheerful".
Comments from visitors included, "the staff are exemplary and treat people with respect. They know everyone's name" and "the staff are very caring."
We found that people's care records were not always appropriately maintained, reviewed and monitored. People had not been fully involved in making decisions about their care.
We also found that safeguarding incidents were not always correctly identified and reported appropriately. This meant that the service had not followed safeguarding procedures and did not give assurance that people were as protected as they should be.
There were insufficient systems in place to identify and analyse incidents that resulted in or had the potential to result in harm to people using the service.

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 12 January 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

Respecting and involving people who use services ✖ Action needed

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was not meeting this standard.

There were insufficient arrangements to ensure that people were supported with decision making and that their views were considered in the planning of care.

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

People we talked to felt that they were treated with dignity and respect by care staff. During our visit we saw some positive interaction between people who live at the home and the staff. The staff addressed people politely and took time to listen to what individuals had to say. One person became distressed and disorientated during our visit and a staff member quickly went to reassure and comfort them.
People told us they were offered choices in their daily lives such as the meals they wanted, activities they preferred and times for getting up and retiring to bed. One person said they went to local church meetings twice a week and was helped to get there and back by another member of the church.

Although people felt involved in choice and decision making, we found that many care plans lacked personalisation around their individual preferences and cultural needs. One person had been living in the home for over 18 months and spoke very little English. There was no record of what attempts had been made to involve the family in their care plan or to access resources such as an interpreter to understand them. While the staff said the person understood English, they spoke in another language throughout our visit.
One person's links with religious organisations were not recorded on their care plan. Records showed that another person had expressed an interest in gardening but care records did not evidence that the service had supported their interest.
People's preferences in respect of their daily routine were not recorded and care documentation did not always provide staff with information about the person's interests or details about the person's life histories. We found limited evidence to show that families or representatives were consulted about people's interests or any contributions from other staff members. This meant that if people found it difficult to communicate their needs there was no information to guide staff on people's preferred routines and to ensure that meaningful and relevant activities were provided.
The care plans contained little information about people's individual wishes with regard to

their care at the end of their life. Mental capacity assessments had not been carried out so it was not clear if people had the capacity to make decisions and give consent about their care and treatment or if they needed support in this area.

Meetings were being held monthly for residents at Foxley Lodge. Records showed that people were consulted about daily life in the home and able to contribute their ideas. In October 2012 for example, there was discussion about activities and the pictorial menu folder.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Care plans did not reflect the most current and agreed care and support for meeting a person's assessed needs and did not give assurance that people using the service experienced effective, safe care and support.

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

Although people using the service have varying degrees of dementia, several of them were able to speak with us and most were quite positive about the home and the staff that were supporting them. Examples of comments from individual residents included, "the staff are all nice" and "no complaints, I'm happy here."

Overall, we saw people to be well dressed and cared for and that staff supported each resident's personal identity with regards to their choice of clothes, hairstyle, make up and accessories that were important to them. One staff introduced us to people and was knowledgeable about their individual needs and preferred names. Staff were alert to changes in people's mood, behaviour and general wellbeing and knew how they should respond to individual needs.
One person felt there was not a great deal to do but they occupied their time by reading the paper and watching TV. We saw that the ability of some residents to take part in activities was limited and as a result, there was a mixture of participation. In the first lounge, some residents were watching TV and the others were sleeping. There was a notice board in the lounge but the activity for the afternoon did not correspond with the displayed activity of 'reminiscence'. We were told that a music entertainer was due to visit instead. We saw there were some dolls and soft toys available to people in the lounge. We observed one person picking at and removing dry skin on their legs. Staff advised that the person often removed their dressings and they often had to contact the district nurse to replace them. Another person spent time walking around the lounge and outside into the garden. Our observation showed that people may have benefitted from more engagement and stimulation.

Peoples' needs were assessed and care and treatment was planned but not always delivered in line with their individual care plan.
We looked at six care plans and found they did not consistently inform and direct staff of the action they needed to take to address people's care needs. For example, one care plan was more a summary of how to deal with behaviours rather than one that identified and addressed the person's needs. For the same person, risk assessments had not been

updated following an incident reportable under safeguarding procedures. In two other care plans risk assessments had not been reviewed since September 2011 and December 2011 respectively.
The language in some care plans was not used in a respectful way. For example one care plan identified a risk of someone "absconding" and another stated that a person was 'verbally abusive'. One example of a person's area of need stated 'resistant to personal care'. In addition, care plans were not person centred and focused on a task rather than how the person would like their support provided. The plans were all written by hand by the manager and were difficult to read in places. The manager advised that they were in the process of typing them up as the home had recently introduced a new care plan format.

Other records showed that people had been supported to access healthcare appointments and there was evidence of ongoing health monitoring. People saw relevant health care professionals and their doctor when they needed and that the home worked with these professionals to keep them healthy. For example, one person was receiving regular visits from the district nurses for treatment of leg ulcers. Another person had involvement with the community mental health team from Croydon local authority.

The provider may find it useful to note that there was no personal profile if a person went missing and important family contact numbers were not readily accessible. The hospital admission sheet on file was limited and only conveyed medical information. This meant that hospital staff may not be aware of important personal information or be able to communicate effectively with the person.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

The majority of people we spoke with said they liked the meals and were offered a choice. One person said they could have sandwiches as a third option if they didn't like the menu. People told us they were asked for their meal selection the evening before.

We observed how people received their meals and what information and options were available to them. We sat with residents in the dining room and observed the lunch time meal which was served at 12.30pm. The staff served each person individually and were available to support those people who needed help with eating.
The food appeared to be warm and the portion sizes looked reasonable. Squash was provided to drink but no alternative was offered. However, most people in the room appeared to enjoy their meal.
The dining room was crowded which meant that some people had difficulty getting to their seat or leaving. The provider's wife advised that the room was laid out slightly differently than usual. We observed that people had a choice about where they ate their meals with some people preferring to eat in their bedrooms.

Daily menus were written on a board on the wall of the dining room and there was a separate photo album of available meals. The food menus mainly reflected English dishes, aside from curry and rice. One person told us they wanted more choice as the meals provided did not reflect their cultural preferences. The provider may find it useful to note that there were other residents from different ethnic backgrounds and a greater choice could be offered to reflect their needs. The provider may also wish to note that dietary preferences were not always recorded in the care plans. This meant that staff may not always be aware of individual food choices or preferences.
Hot and cold drinks were offered to people throughout the day.

We saw that residents' weights were being monitored regularly and screening had been undertaken for one person at risk from poor nutrition or dehydration.

Safeguarding people who use services from abuse ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People who use the service were not fully protected from the risk of abuse. Safeguarding procedures were not always used appropriately to help protect people from harm and keep people safe.

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

People we spoke to said that staff treated them well, were respectful and never rude. A relative told us they were happy that their family member was "secure and safe".

One staff we spoke with told us that they had received safeguarding training and were able to describe what action they would take. However, they were less clear about the role of external agencies involved in safeguarding vulnerable adults. The home's safeguarding policy was dated 2009. The procedure did not reflect the most current guidance and legislation for safeguarding vulnerable adults and the manager was unaware of the revised policy. During our visit we also spoke to the registered provider on the telephone and they were also unclear about the latest legislation. Staff had received safeguarding training in April 2012 through an external company that provided the majority of the home's training. The provider may find it useful to note that the company may not be using the most up to date safeguarding legislation for delivering training.

Records showed that safeguarding concerns were not always correctly identified and reported appropriately. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect. For example behaviour record charts and incident reports for one person showed that two incidents had occurred on the 17 and 18 November which were reportable under the PAN London Guidance.(Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse). The manager told us they had not thought it applicable to make an alert as the incidents were part of the person's behaviour which the service was finding difficult to manage. The manager had sought advice from other agencies and advised that they were awaiting a date for a meeting to review the person's needs and placement.
On the 20 November there was a further incident of a safeguarding nature but no recorded evidence that this was referred to the local authority. The manager advised that the incident was reported to the safeguarding team by telephone but was unsure if CQC had been notified. Our records showed that the home failed to share this information with us at the time of the incident. Following our visit the provider submitted a corresponding

notification and the manager agreed to raise an alert for the other two safeguarding concerns. We also contacted the local council's safeguarding team to confirm whether the three incidents had been reported. We were informed that the incident on the 20 November was reported promptly on the 21 November but the two earlier incidents were not reported until the 26 November.

The failure to report incidents in a timely manner and to the relevant agencies meant that the service had not followed safeguarding procedures correctly. This meant there was a risk that people using the service were not being fully protected from abuse or the risk of abuse.

Some people using the service show behaviours that present a risk to themselves or others. Records confirmed that training around dementia care and coping with challenging behaviour had been completed by staff.

Assessing and monitoring the quality of service provision ✖ Action needed

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 not meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.
However, there were limited systems in place to identify, assess and manage risks to the health, safety and welfare of people using the service.

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 spoke to people using the services but their feedback did not relate to this standard.
Records supported that some audits and checks were being carried out on a regular basis. These looked at areas such as medication administration, the environment and heath and safety tests on call bells and water temperatures, for example.
There were appropriate maintenance contracts concerning fire alarms and appliances and for gas and electrical safety. Records were up to date and evidenced that equipment was routinely checked and safe for people to use.
After our visit, we asked the manager to send us a list of training topics that staff had undertaken. This showed that the majority of staff were up to date with mandatory training and had received other specific training to meet people's assessed needs. Examples included dementia training in July, nutrition in August and mental health awareness in October 2012.

The home did not have an effective system in place to analyse incidents which resulted in, or had the potential to, harm people. For example there had been 12 accidents recorded for the month of October. The home also had a quality assurance monitoring visit from Croydon council commissioners in September 2012. In their report it was noted that there had been 74 incidents or accidents within the last six months. It was not clear what preventative measures or strategies were in place to reduce or prevent repeat occurrences. This meant that risks to people had not been fully assessed and were at risk of recurring. As a consequence, any trends or themes may not be identified, which may increase the risk of poor health outcomes.

People who use the service, their representatives and staff were asked for their views about their care and treatment but they were not always acted on.
We saw that people using the service and their relatives were given questionnaires in April 2012. Although feedback was mostly positive about the care provided, one relative had made a negative comment about an unpleasant odour. There was no record however that

the matter had been looked into or that the provider had responded to their comments. The provider may wish to note that there was no quality assurance plan in place that would highlight any strengths and weaknesses in the service as well as planned improvements.

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 activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: There were insufficient arrangements to ensure that people were supported with decision making and that their views were considered in the planning of care. Regulation 17 (1) (b)
Regulated activity	Regulation
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**
	How the regulation was not being met: Care plans had not been reviewed, did not include up to date information for staff on how to meet individuals' needs and did not ensure the safety of people who use the service. Regulation 9 (b)(i) (ii).
Regulated activity	Regulation
Accommodation for persons who require	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010**

This section is primarily information for the provider

nursing or personal care	**Safeguarding people who use services from abuse**
	How the regulation was not being met: The provider had not ensured that an appropriate response to abuse allegations always took place and that appropriate procedures were followed. Regulation 11 (1) (b)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The provider had insufficient systems in place to identify and analyse incidents that resulted in or had the potential to result in harm to people using the service. Regulation 10 (2)(b)(c)

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 12 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.

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

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