Inspection Report

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

Folkestone Nursing Home

25 Folkestone Road, East Ham, London, E6 6BX Tel: 02085484310

Date of Inspection: 13 November 2012 Date of Publication: December 2012

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Cleanliness and infection control	✓ Met this standard
Management of medicines	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Folkestone Nursing Home
Registered Manager	Mr. John Evans
Overview of the service	Folkestone Nursing Home is a 43 bedded nursing home for older people with dementia care needs. The service occupies a purpose built premises in East Ham, within the London Borough of Newham.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures 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 13 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, talked with staff and talked with stakeholders.

What people told us and what we found

We were told that most people living at Folkestone Nursing Home had dementia care needs and 22 people had additional nursing care needs.

We found the environment in which people lived was clinical and not homely. Some people's rooms were sparsely decorated and contained little or no personal possessions. There was an unpleasant urine odour in most parts of the home. We were told this was a result of un-managed incontinence and/or behavioural issues.

People that used the service told us that they were generally happy living at Folkestone Nursing Home. Most people were unable to tell us about their experiences due to their dementia care needs but some comments made were, "we are looked after well, good carers who do what they can for you", "I get up and go to bed when I want", "if you speak to the cook about what food you like they will get it for you", "this is a nice place, my room is cosy and nice, I even have my own fridge."

Although people said they were happy with the care they received, some people said they would like to have more to do. We were told "there's not a lot to do, that's what it's lacking in", "weekends are more boring, more going out would be good."

Since the last inspection the registered manager has resigned and a new manager was appointed in September 2012. We did not meet this manager at this inspection.

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 04 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

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

We looked at four care files and saw they contained a signed 'Consent to Care' form. One person, who had been identified as having limited capacity, had an appropriate mental capacity assessment on file and a deprivation of liberty safeguard had been obtained through the relevant processes and authorities.

People that used the service said they felt involved in the decisions made about their care. One person said "I like it here very much, people are helpful and sociable and I am able to make my own choices."

One person's relative told us that staff always asked for consent before providing any care or treatment.

We spoke to staff who demonstrated a good awareness of consent issues. Staff spoken to recognised that even if someone had previously given their consent for something, they still needed to check that the person was still consenting. They said if someone refused personal care they would ask again later on or take a different approach. Although staff said they were aware of this, we did observe one carer put clothing protectors on people before they had their lunch without any explanation of what they were doing and without asking for their consent.

Throughout our visit we heard staff talking to people that used the service and found that most were respectful in their approach. One person complained of a headache and staff were heard offering pain relief and asking permission to take their temperature. On another occasion we observed part of a medication round. We saw that the nurse administering medicine checked the person understood what was being offered, and that they were consenting to take their medicine before they administered it.

We were made aware of one person who could not speak or understand English and others who had some basic understanding of the English language. We were told that there were no staff employed who were able to speak in this person's first language and only a few staff who were able to speak in the others' languages.

The provider may wish to note that although people had given formal consent to care there was no 'Consent to Care' policy in place. This is particularly important for those persons whose first language is not English.

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.

People that used services did not always experience care, treatment and support that met their needs.

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

We looked at five care plans and found they reflected a nursing model of care. Although appropriate for some people, a more person centred approach could better support people with dementia care needs. Not all care files contained information regarding the person's life history and/or end of life preference and plans.

People's needs had been assessed and staff were appropriately monitoring people's health. Staff we spoke to on the day of the inspection were knowledgeable of the contents of people's risk assessments and how to deal with these risks when they arose. People were regularly weighed and assessed for the risk of malnutrition. Regular formal assessments of people's risk of falling and their skin integrity were carried out. Staff were able to explain how they ensured that people's skin integrity was maintained, including those people at the home who were cared for in bed.

Staff completed daily care records, which contained information about people's health, behaviour and activity.

Staff confirmed and we saw evidence that other health and social care professionals were regularly involved in the care and welfare of people that used the service. This included GPs, social workers, opticians and chiropodists.

One person's relative told us that their relative received appropriate care. They said that when their relative had acquired some medical problems, care staff had dealt with them satisfactorily.

Although we found people's physical health care needs had been identified and provided for, we were concerned that not all people with continence and/or behavioural issues had been supported appropriately. Staff told us that the unpleasant urine odours which we noted through most parts of the home, were due to people who were incontinent refusing the support offered. Where the staff are unable to support an individual with their care needs, specialist health care advisors should be involved in assessing peoples needs and exploring alternative options.

Staff said that they had time during the day to spend time talking to people. They said that people engaged in activities on a daily basis. We saw that the home had made efforts to identify what activities people wished to participate in. The home had an activity co-ordinator. We saw the co-ordinator in one lounge playing cards with a person living at the home. Other people at the home were playing a game together and there was a good atmosphere in the lounge. However, in the other two lounges on the first and second floor, we found that no activities were being provided during the inspection. Whilst staff were interacting with some people, including sitting down and speaking with them in a caring way, some people were, at times, not engaged with.

People told us they received good care. They said the "staff are very good" and "we are well looked after, fed well. Good carers, do what they can for you". Although people offered positive comments about the care they received, people also said "there's not enough to do", "weekends are more boring. Going out more would be good" and "I've got no one to go out with. Staff have never offered to take me out. I'd love to go to the theatre or to see a pantomime".

One relative told us that their relative was encouraged and got to participate in activities.

We were told that people that used the service were given a choice of meals each day and saw that the chef had recorded the choices which had been made by some people. However when we observed lunch, we saw that all food had been pre-plated before being sent to the lounge/dining areas. It was difficult to see how people with high dependency dementia care needs were actually being given a real choice about what they wished to eat.

We saw that only a few people sat at the dining tables for lunch; most people had their meals served to them on a small table placed in front of their day chair. We noted that these small tables remained in front of some people for most of the day. This could act as a physical and visual barrier to people. We saw one person trying to get up whilst a table was in front of them, but who then sat down as they appeared to be having difficulty in getting out from their chair.

We saw that most people were being appropriately supported to eat their food, however two staff members were seen feeding people from a standing position which was not good practice. Those people on a pureed diet had their three pureed items mixed together before it was placed in front of them. We did not hear the staff serving these meals ask these people if this was how they wished to eat their meal. We noted that most people did not have a drink offered with their meal and no condiments were available.

People told us that in general the food "wasn't bad, a bit hit or miss, but today the casserole was very good", and "the food's very good, you're not really given a choice unless you are diabetic or a vegan. The cook does come and talk to you about what you like though."

We were concerned to hear some staff gave orders to people rather than encouraged or explained what was required of them. For example on one occasion, we saw one person being told to "sit down" a number of times when they would not sit down for their lunch. On another occasion, we saw a person being hoisted by staff. The staff member when putting the strap around the person, pulled this firmly, which made the person unnecessarily jolt forward. When lifting them, the staff member abruptly said "feet up", "lean forward", "You're going to stand up for her. Please. Thank you" and then said "We're going to the

toilet", which could be heard across the lounge by other people.

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

Although people were protected from the risk of infection because appropriate guidance had been followed, there was an unpleasent urine odour throughout most of the home due to un-managed incontinence/behavioural issues.

Reasons for our judgement

We were told that all cleaning was undertaken by dedicated cleaning staff.
We looked at the cleanliness of the home and found that although it was visibly clean, there were unpleasant odours throughout most of the home. Staff told us they were unable to remove the odours due to the continence and or behavioural issues of some people that used the service.

Staff told us that working on this floor was difficult at times due to the odour. We found the strong smell of urine was unacceptable for the people expected to live with it.

We saw evidence that appropriate arrangements were in place to prevent and control infection. There was an infection control policy in place and staff had received infection control training. Staff were able to explain what action they should take to ensure that infections were prevented and or controlled. Staff said that they washed their hands after caring for each person and used clean gloves and aprons for each person they provided personal care to. Staff explained that they regularly changed people's incontinence pads and applied creams to their skin to prevent infections. They said that they knew what action to take in the event of bodily fluids being spilled on the floor.

We saw that protective equipment, such as gloves and aprons, were readily available for use by staff. There were also sufficient hand washing facilities for everyone living and working in the home, including soap and paper towels.

Appropriate arrangements were in place for dealing with clinical and other waste and contracts were in place for both clinical and domestic waste. Staff spoken to were able to explain how they should dispose of clinical waste safely.

Management of medicines ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

All medicines were securely stored in locked trolleys, cupboards or fridges. The medicines room was locked and only registered nurses had access to the keys.

Staff had access to the Nursing and Midwifery Council's (NMC) medicines guidance. Nursing staff said that they had received training in administering medicines.

We checked a range of medicines in the controlled drugs cupboard, medicines trolley and medicines fridge. We found that all medicines were within their expiry date. Medicines that were prescribed for or to be given to a specific person, were clearly labelled. Where medicines had a 'best before' date once they had been opened, the date the medicines had been opened was written on the medicine packet or bottle. Medicines Administration Records (MAR) charts were colour coded to enable staff to determine the time of day that medicines should be administered. A photograph of the person was attached to each MAR chart in order to prevent the administration of medicines to the wrong person.

We cross-referenced some of the medicines in a drugs trolley with MAR charts. We found that the medicines recorded as being given to people matched the medicines remaining in the trolley.
However, we found that on several occasions, the registered nurse on duty had not signed the medicines administration record to confirm that the medication had been taken.

On checking the controlled drugs prescribed to people living at the home, we found that the medications remaining matched the controlled drugs records. We also found that on a number of occasions, care assistants had counter-signed the controlled drugs book. On reviewing staffing records and speaking with the deputy manager, we established that the care assistants had not had training in medications. This was not in line with the NMC medicines guidance that the home was using.

We found that several people at the home had refused medicines. Appropriate action had been taken by the home in response to this. Covert medicines arrangements had been put in place for these people and the consent of people's next of kin and GP had been obtained. There was recorded evidence that various attempts had been made to administer medicines prior to convert arrangements being put in place and the nursing staff were able to explain who was receiving covert medications and the process they

followed.

One person's relative said that their relative always got their medication.

We saw the nurse administering the afternoon medication ask people if they were ready for their medication and ensure they had given consent, before it was given to them.

The deputy manager explained that medicines were audited every month. We found that detailed medicines audits were carried out, although this had not been done monthly. Only two audits had been carried out in 2012, with the most recent in April.

To ensure that medicines were stored in an appropriate environment, the temperature of the medicines fridge was recorded by staff every day. We looked at these records and found at times that the minimum/maximum temperatures went outside of the parametria for storing medicines. This had occurred on a number of occasions in September and October 2012 and on eight occasions in November 2012 .There was no policy in place to deal with this and staff spoken to were unable to explain what action they would take.

Staff had access to the Nursing and Midwifery Council's (NMC) medicines guidance. Nursing staff said that they had received training in administering medicines.

Requirements relating to workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

We found that appropriate recruitment checks had been carried out. On checking six staff files we found that the appropriate information had been obtained. We found that the home had carried out Independent Safeguarding Authority (ISA), Adult First and Criminal Records Bureau checks, obtained two references from previous employers and established people's identity. Prospective employees had completed an application form.

Despite relevant checks, we found that evidence of one staff member's right to work in the UK could not be provided and staff were unable to provide evidence of a recruitment policy or procedure.

We spoke to staff about their experience and all verified that they had completed an application form, attended a formal interview and had provided relevant pre-employment documents prior to starting work in the home.

Records ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

People's personal information was held securely but still accessible to those who needed access.

We found that most people's care plans were accurate and contained appropriate information in relation to their care and treatment. The care plan for one person who had recently been admitted to the home was incomplete, although there was a reasonable explanation for this. However, the person had suffered a suspected epileptic seizure and there was insufficient information on this person's file about what staff should do in the event of a further seizure.

Daily records were detailed and most risk assessments such as falls and skin integrity were up to date and had been regularly reviewed. We did however see one person's risk assessments had not been reviewed since 15 September 2011.

The home kept appropriate records of accidents that had occurred in the home. We were also shown fire safety and maintenance records by the person responsible for the day to day maintenance of the home.

On reviewing the complaints records, we found one only formal complaint on file for 2011 and 2012. Whilst this had been responded to, there was no evidence that the matters raised had been resolved.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The planning and delivery of care did not always meet the needs of the people that used the service. Regulation 9 (1)(b)(i)(iii)

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 04 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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