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 Inspections: 24 January 2014
17 January 2014

Date of Publication: March 2014

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✖ Action needed
Complaints	✓ Met this standard
Records	✖ Action needed

Details about this location

Registered Provider	Folkestone Nursing Home
Registered Managers	Mr. Kreshnadeo Ramanah Mrs. Rachelamma Thomas
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

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Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Folkestone Nursing Home had taken action to meet the following essential standards:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Complaints
- Records

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 17 January 2014 and 24 January 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 reviewed information given to us by the provider. We talked with other authorities.

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

What people told us and what we found

People's privacy and dignity was not always respected. Their views and experiences were not always taken into account in the way the service was provided and their independence was not always promoted.

Care plans showed a person centred approach to care. However, there was insufficient written evidence to demonstrate that care was provided in line with the information recorded in peoples care plans. Risk assessments were in place but steps to minimize risks were generic.

Not all staff had received training in safeguarding vulnerable adults, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). We spoke with staff about the Mental Capacity Act 2005 and DoLS and only two staff were able to demonstrate a clear understanding.

The provider had produced a complaints procedure in a format that was accessible to all. The activities coordinator had discussed the procedure with everyone living in the home. People said they would be able to raise their concerns.

Records contained insufficient information to demonstrate that care was always provided

safely and people's daily records did not demonstrate that they received personal care at the time and in a manner they had agreed to.

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 28 March 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where we have identified a breach of a regulation during inspection which is more serious, we will make sure action is taken. We will report on this when it is complete.

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.

People's privacy, dignity and independence were not always respected and people's views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care.

We have judged that this has a moderate impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

At our last inspection on 05 September 2013 we found that people's privacy was not always respected and their views and experiences were not always taken into ac-count in the way the service was provided. Some people we spoke with said they were sometimes been bothered by the behaviour of others and did not feel that the situation was being managed. The provider submitted an action plan to address the issues identified with a completion date of 30 November 2013.

On the first day of our inspection the nominated individual confirmed that actions set out in the provider's action plan had been achieved. However, on the evening on 17 January 2014 we observed the 20:00hrs handover by care staff on the ground floor. This took place room to room for those people located in their bedroom at the time of the handover, and in the lounge/dining room for those individuals located in the lounge. The handover detailed each person's health and social wellbeing which compromised the dignity and confidentiality of those individuals located in the lounge.

Throughout our inspection we observed that most bedroom doors were held open by a magnetic holder. Although we did not enter bedrooms we could see people from the communal corridor in varying states of undress either in bed or standing in their room, which compromised their dignity. We asked staff why most bedroom doors were held open and we were told that some people did not like their doors closed. We looked at five randomly selected care plans for those people whose bedroom door was seen to be held open. There was no evidence to support that this was the choice of or had been agreed by the person occupying the bedroom.

The nominated individual told us that a key assessment form had been devised to enable

those people wishing to hold their own bedroom door keys to be supported to do so. We spoke with staff about this form but they had not been made aware of this. Staff spoken with confirmed that the situation regarding a person's right to hold their own key had not changed and only three people could be identified as having being given the opportunity to hold their own key.

People's views and experiences were not taken into account in the way the service was provided and delivered in relation to their care. During our inspection we saw that the small meeting/reminiscence room had been converted to a bedroom. We were told by staff, people who use services and a relative that they were unhappy that the decision to change the use of this room had been taken by the management of the home without consultation. We were told that the use of this room as a communal space for reminiscing, meetings and maintaining a level of independence had been requested by, fundraised for and set up by the activities co-ordinator with support from people who used services and their relatives. We spoke to the registered manager and nominated individual who confirmed that the use of this room had been changed without consultation.

People who used services and relatives also told us about a change in the staffing arrangements at the home where they felt they had not been sufficiently consulted. The registered manager and nominated individual confirmed that staffing arrangements had been changed without consultation.

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 and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare.

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

On the second day of our inspection we visited the home out of hours arriving at 4am so we could see the night time and early morning routine. When we arrived there were four care workers and one qualified nurse on shift. We were told that this was the usual number of staff on shift throughout the night which was reflected on the staff rota. We found only one person who used the service was awake and dressed by 4.30am, everyone else appeared to be sleeping or resting in their bedrooms.

At 5am we saw two people sitting on a chair in their bedrooms dressed but asleep. We asked staff about this and were told they liked getting up early. We looked at the care plans for these two people but neither had their preference for getting up recorded.

Care plans showed a person centred approach to care. However, there was insufficient written evidence to demonstrate that care was provided in line with the information recorded in peoples care plans. Risk assessments were in place but steps to minimize risks were generic, for example one person identified as being at a high risk of falls did not have an individualised risk assessment in place. Although there were steps to guide staff to offer safe care this person had not been identified as in need of bed rails to prevent falls at night. This person had a fall within the first 24 hours of admission which resulted in a significant injury.

We saw some positive examples of care, such as staff closing doors before carrying out personal care and one nurse was seen to make several attempts at encouraging a particular person to accept their morning medication which they were refusing to take. Some people told us that they were happy with their care whilst others showed signs of not having their needs met. For example one person was heard calling out and was seen banging the side of their bed for ten minutes. We went to see if we could help this person as all staff were busy but we were informed that they required support with their personal care. Another person who staff said liked to spend most of their time in their room, appeared to welcome our presence and needed a lot of encouragement to allow us leave.

We spoke with staff working the night shift. They were knowledgeable about people's needs and were seen to be very busy between the hours of 6.30am and 8am. During this time we observed people being woken up and we shadowed the nurse in charge from 6.30am through to the end of their shift at 8.30am. During this time some people were woken up by the nurse who carried out health care tasks such as blood sugar testing, percutaneous endoscopic gastrostomy (PEG) feeding and food supplements. Those people who required their blood sugar levels testing were seen to have their finger wiped with a dry paper hand towel both before and after the procedure. We also saw that the same paper towels were used to wipe people's faces which we discussed with the nurse. We were told that usually softer towels were used and paper serviettes were pointed out. We questioned whether the use of softer facial tissues would be kinder and a more pleasant experience for people and were told 'yes that would be nice'.

We witnessed one person who had been standing in the corridor near their bedroom escorted to the lounge/dining area by a staff member. This person complained that the staff member had taken hold of 'their sore arm' and refused to move until they supported them from their opposite side. We noted that this person had undergone a surgical procedure which may have accounted for their discomfort.

During our night visit we saw two people had an arm chair strategically placed next to their beds to prevent them from either falling from bed or climbing out. We looked at the care plans for these two people and found the use of bedrails had been identified to prevent them from falling out of bed. When we spoke to staff about the positioning of the chairs they appeared not to understand that this was neither a safe or acceptable means of preventing a person from falling out of bed.

At 8.10am we were made aware that one person had become locked in their bedroom due to a faulty door lock. At 9.30am we witnessed the home administrator removing the door handle in an attempt to get into the room. We heard the person trapped in the room calling for food and saying they felt very weak and dizzy. Staff were only heard responding to this person once we had suggested they needed some reassurance. Shortly afterwards the door was released and the person was given their breakfast. We did not witness any explanation or apology by staff for the distress caused to this person. We spoke to this person about their care and they told us 'this place has taken all of my strength away, I need to eat otherwise I don't feel well'. We looked at this person's care plan and found they were diabetic.

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 protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

We have judged that this has a moderate impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

At our last inspection on 05 September 2013 we found less than half of the permanent staff had received safeguarding vulnerable adults training in the last three years and only nine staff had undertaken any training in the Mental Capacity Act 2005. Staff we spoke with were not aware of the providers' whistleblowing policy and although staff had an understanding that people should not have unnecessary restrictions imposed on them, they had not received any training in the Deprivation of Liberty Safeguards (DoLS).

At this inspection we found that of the 55 staff employed only 27 had received training in safeguarding vulnerable adults, 18 in the Mental Capacity Act 2005 and 7 in DoLS. We spoke with staff about mental capacity and DoLS and only two staff were able to demonstrate a clear understanding.

Although people had risk assessments in place these gave a generic approach to minimising identified risks. We were concerned that one person with a history of falls had not been provided with bed rails to help minimise the risk of falls. This person had sustained a significant injury from a fall on their first night in the home. A formal notification had been made to the Care Quality Commission (CQC) showing this person had fallen. However, we were concerned that this person had not been sent to hospital for an x-ray. We spoke to two nurses and a care worker about the falls policy. We were told that any fall should be considered serious and following examination and monitoring any person sustaining a fall should be referred to hospital. We raised a safeguarding alert with the local authority safeguarding team as the provider had not followed their falls policy on this occasion.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

At our last inspection on 05 September 2013 we found the complaints procedure was not in a format accessible to all people who used the service.

At this inspection we found the complaints procedure had been produced in two alternative formats, one using simple words and another in a pictorial format. The activities coordinator was able to evidence how they had discussed with everyone living in the home how they could raise a concern.

We were shown evidence that the complaints procedure was also discussed in the 'residents and relatives' meeting. We were told that a complaints/suggestion box had been situated in the reception area of the home to encourage its use.
Those people we spoke to about complaints said they would be able to raise their concerns with someone, staff, a family member or external professional.

We looked at the record of complaints and found they had been dealt with in line with the provider's procedure.

Records ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

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 were concerned that one person newly admitted to the service had a fall which resulted in a significant injury. This person had not been referred to hospital for three days. We checked the preadmission assessment record, accident report and daily records for this person and were concerned that there was insufficient information to demonstrate that appropriate steps had been taken in a timely manner.

Records did not demonstrate that people received personal care at a time and in the manner they had agreed to. We looked at a random sample of care plans and cross referenced these against the daily records for each person. None of the daily records we looked at reflected that care had been offered or given as identified and agreed in their care plan. For example, one person who we observed to be in need of personal care support on the second day of our visit, had a care plan that stated 'to be offered a shower at least twice a week and shaves every day'. The daily notes for this person stated 'self-toileting requires minimal assistance with all care needs'. We saw that this person had not had a shave but there was no information to support that this had been their choice. In addition there was no recorded evidence that this person had had or had been offered support with a shower in the last week.

We looked at the night reports at 4.45am and found these had been completed for most people. These reports were all very similar told the reader very little about the individual care offered to each person during the night, for example 'x appears to have had a settled night. Personal hygiene care needs met. Ate and drank well. Safety checks maintained'. There was no evidence of what safety checks had been carried out and no monitoring charts for specific healthcare support such as turning for those people at risk of developing pressure ulcers.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care that is inappropriate or unsafe, by means of the planning and delivery of care and, where appropriate, treatment in such a way as to meet the service user's individual needs, ensure the welfare and safety of the service user. Regulation 9 (1)(b)(i)(ii)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: The registered person must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user.

This section is primarily information for the provider

	Regulation 20 (1)(a)

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 28 March 2014.

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 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.

✓ **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. 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:

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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