Unannounced Primary Inspection

Name of Establishment:	**Camphill Care Home**
Establishment ID No:	**1455**
Date of Inspection:	**03 June 2014**
Inspector's Name:	**Bridget Dougan**
Inspection No:	**17092**

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 8225 2544

1.0 General Information

Name of Home:	Camphill Care Home
Address:	62 Toome Road Ballymena BT42 2BU
Telephone Number:	(028) 2565 8999
E mail Address:	camphill@fshc.co.uk
Registered Organisation/ Registered Provider:	Mr Jim McCall Four Seasons Health Care Ltd
Registered Manager:	Ms Valerie Reynolds
Person in Charge of the Home at the time of Inspection:	Ms Dulce Amor Yanga-Ali (acting manager)
Registered Categories of Care and number of places:	Nursing - I, PH, PH(E), DE, MP(E) - one identified patient 72
Number of Patients Accommodated on Day of Inspection:	63
Date and time of this inspection:	03 June 2014: 12.30 – 16.30 hours
Date and type of previous inspection:	03 December 2013 Secondary Unannounced

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect nursing homes. A minimum of two inspections per year is required.

This is a report of a primary announced inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection were met.

3.0 Purpose of the Inspection

The purpose of this inspection was to consider whether the service provided to patients was in accordance with their assessed needs and preferences and was in compliance with legislative requirements, minimum standards and other good practice indicators. This was achieved through a process of analysis and evaluation of available evidence.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

The aims of the inspection were to examine the policies, practices and monitoring arrangements for the provision of nursing homes, and to determine the provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008)

Other published standards which guide best practice may also be referenced during the Inspection process.

4.0 Methods/Process

Committed to a culture of learning, the RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the DHSSPS Nursing Homes Minimum Standards 2008.

The inspection process has three key parts; self-assessment (including completion of self -declaration), pre-inspection analysis and the inspection visit by the inspector.

Specific methods/processes used in this inspection include the following:

- analysis of pre-inspection information
- discussion with the registered manager
- examination of records

- consultation with stakeholders
- tour of the premises
- evaluation and feedback.

Any other information received by RQIA about this registered provider has also been considered by the inspector in preparing for this inspection.

5.0 Consultation Process

During the course of the inspection, the inspector spoke with:

Patients	**30**
Staff	**20**
Relatives	**2**
Visiting Professionals	**0**

Questionnaires were provided, during the inspection, to patients, their representatives and staff to seek their views regarding the service. Matters raised from the questionnaires were addressed by the inspector in the course of this inspection.

Issued To	**Number issued**	**Number returned**
Patients	**8**	**5**
Relatives / Representatives	**6**	**1**
Staff	**6**	**3**

6.0 Inspection Focus

The inspection sought to establish the level of compliance achieved regarding the selected DHSSPS Nursing Homes Minimum Standards.

The criteria from the following standards are included;

- Management of Nursing Care – Standard 5
- Management of Wounds and Pressure Ulcers –Standard 11
- Management of Nutritional Needs and Weight Loss – Standard 8 and 12
- Management of Dehydration – Standard 12

An assessment on the progress of the issues raised during and since the previous inspection was also undertaken.

The inspector will also undertake an overarching view of the management of patient's human rights to ensure that patients' individual and human rights are safeguarded and actively promoted within the context of services delivered by the home.
The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance statements		
Guidance - Compliance statements	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

7.0 Profile of Service

Camphill Care Home is situated in a quiet residential area, but is convenient to the facilities of Ballymena.

It is a single storey; purpose built home which can accommodate a maximum of 72 persons all in single bedrooms.

Accommodation is provided in three separate units. The Glenariff Suite has 30 beds, the Glenshesk Suite has 12 beds and the Glendun Suite has 30 beds. The Glenshesk and Glendun Suites accommodate patients with dementia.

Sanitary facilities, bedrooms, communal lounges and dining facilities are available in each suite. Laundry and catering facilities are also provided. A large car park is available with an entrance to each suite.

The home is registered to provide nursing care for persons under the following categories of care:

I	Old age not falling into any other category
PH	Physical disability other than sensory impairment
PH (E)	Physical disability other than sensory impairment – over 65 years
DE	Dementia
MP(E)	Mental Disorder excluding learning disability or dementia - over 65 years (one identified person only)

The certificate of registration issued by the Regulation and Quality Improvement Authority (RQIA) accurately reflected the categories of care and was appropriately displayed in a prominent position of the home.

8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary inspection (unannounced) to Camphill Care Home. The inspection was undertaken by Bridget Dougan on 03 June 2014 from 12.30 to 16.30 hours.

The inspector was welcomed into the home by Ms Dulce Amor Yanga-Ali (Acting Manager). The registered manager was on leave at the time of this inspection. Ms Dulce Amor Yanga-Ali was available throughout the inspection and for verbal feedback of the issues identified during the inspection at the conclusion of the inspection.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one.

During the course of the inspection, the inspector met with patients, staff and one relative. The inspector observed care practices, examined a selection of records and carried out a general inspection of the nursing home environment as part of the inspection process.

Questionnaires were issued to patients, staff and one relative during the inspection.

The inspector spent a number of extended periods observing staff and patient interaction. Discussions and questionnaires are unlikely to capture the true experiences of those patients unable to verbally express their opinions. Observation therefore is a practical and proven method that can help us to build up a picture of their care experience.

These observations have been recorded using the Quality of Interaction Schedule (QUIS). This tool is designed to help evaluate the type and quality of communication which takes place in the nursing home. A description of the coding categories of the Quality of Interaction Tool is appended to the report at appendix two.

As a result of the previous inspection conducted on 03 December 2013 five requirements and seven recommendations were issued. These requirements and recommendations were reviewed during this inspection. The inspector evidenced that four requirements and seven recommendations had been fully complied with. One requirement has been assessed as moving towards compliance. Details can be viewed in the section immediately following this summary.

Standards inspected:

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed. (Selected criteria)

Standard 8: Nutritional needs of patients are met. (Selected criteria)
Standard 11: Prevention and treatment of pressure ulcers. (Selected criteria)
Standard 12: Patients receive a nutritious and varied diet in appropriate surroundings at times convenient to them. (Selected criteria)

Inspection Findings:

- **Management of Nursing Care – Standard 5**

The inspector can confirm that at the time of the inspection there was evidence to validate that patients receive safe and effective care in Camphill Care Home.

The inspector inspected four patients care records and there was evidence of comprehensive and detailed assessment of patient needs from date of admission. This assessment was found to be updated on a regular basis and as required. A variety of risk assessments were also used to supplement the general assessment tool. The assessment of the patient's needs was evidenced to inform the care planning process.

Comprehensive reviews of the assessments of need, the risk assessments and the care plans were maintained on a regular basis plus as required.

Inspection of four patients care records confirmed that written evidence was maintained to indicate that discussions had taken place with patients, and their representatives in regard to planning and agreeing nursing interventions.

There was also evidence that the referring HSC Trust maintained appropriate reviews of the patient's satisfaction with the placement in the home and the quality of care delivered.

Compliance Level: Compliant

- **Management of Wounds and Pressure Ulcers –Standard 11**

The inspector evidenced that wound management in the home was well maintained. There was evidence of appropriate assessment of risk of development of pressure ulcers which demonstrated timely referral to Tissue Viability professionals for guidance and pressure relieving equipment. Care plans for the management of risks of pressure ulcers and wound care were maintained to a professional standard. One recommendation has been made for care assistants to receive a training update on the prevention of pressure ulcers.

Compliance level: Substantially Compliant

- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12**

The inspector reviewed the management of nutrition and weight loss within the home.

Robust systems were evidenced with risk assessments and appropriate referrals to GP's, speech and language therapists and or dieticians being made as required. Inspection of staff training records revealed that staff as appropriate received a training update on the management of Dysphagia.

The inspector also observed the serving of the lunch meal and can confirm that the patients were offered a choice of meal and that the meal service was well delivered. Patients were observed to be assisted with dignity and respect throughout the meal.

Compliance level: Compliant

- **Management of Dehydration – Standard 12**

The inspector also examined the management of dehydration during the inspection. The home maintained a record of the fluid balance of those patients assessed at risk of dehydration. There was evidence that fluid balance records were maintained appropriately.

Patients were observed to be able to access fluids with ease throughout the inspection.

Compliance level: Compliant

Patients / their representatives and staff questionnaires

Some comments received from patients and their representatives:

“Everything is very good. I had a hearing aid but I lost if before I came into this home. I would like another as I am very hard of hearing.”

“Staff here are excellent. I am waiting on an OT assessment for discharge home. This is a slow process. I would like this followed up, otherwise I couldn’t find fault with the care here.”

“The care is very good and staff are excellent. My mother is very happy here.”

The issues identified during discussion with patients were discussed with the acting manager who agreed to address them.

Some comments received from staff:

“I am content of the care provided in this home. Our residents are treated with respect and dignity by staff.”

A number of additional areas were also examined

- Records required to be held in the nursing home
- Guardianship
- Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS)
- Patient and staff quality of interactions (QUIS)
- Complaints
- Patient finance pre-inspection questionnaire
- NMC declaration
- Staffing and staff comments
- Comments from representatives/relatives *and visiting professionals*
- Environment.

Full details of the findings of inspection are contained in section 11 of the report.

Conclusion

The inspector can confirm that at the time of inspection the delivery of care to patients was evidenced to be of a good standard. There were processes in place to ensure the effective management of the themes inspected.

The home’s general environment was well maintained however one requirement is made in regard to the repair/ replacement of a number of double glazing units which had moisture between the glasses.

Patients were observed to be treated with dignity and respect.

However areas for improvement are identified two requirements and two recommendations are made. These requirements and recommendation are addressed throughout the report and in the Quality Improvement plan (QIP).

The inspector would like to thank the patients, the visiting relative, acting manager, registered nurses and staff for their assistance and co-operation throughout the inspection process.

9.0 Follow-up on Previous Issues

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	15 (2) (a)	The registered person shall ensure that the assessment of the patient's needs is kept under review.	Review of four patients care records evidenced that this requirement had been met.	Compliant
2	16 (2) (b)	The registered person shall ensure that the patient's care plan is kept under review.	Review of four patients care records evidenced that this requirement had been met.	Compliant
3	27 (2) (b)	The registered person shall having regard to the number and needs of the patients, ensure that the premises to be used as the nursing home are of sound construction and kept in a good state of repair externally and internally. Doors and architraves were damaged throughout the home. These should be repaired/ replaced.	Inspection of the environment confirmed that a number of door and architraves had been repaired, however a number of damaged doors/architraves remained. The acting manager confirmed that this work is still in progress. This requirement will therefore be stated for the second time and the registered person is required to submit timescales for completion of this work.	Moving towards compliance
4	13 (7)	The registered person shall make suitable arrangements to minimise the risk of infection and toxic conditions and the spread of infection between patients and staff.	New vinyl floor covering has been laid in the dining room. Therefore this requirement has been met.	Compliant
5	24 (2)	The complaints procedure should reflect the regional guidelines for the management of complaints	The inspector can confirm that this requirement has been met.	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	5.6	The registered manager should ensure that contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.	Review of four patients care records evidenced that this recommendation had been met.	Compliant
2	11.4	The registered manager should ensure that a validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan is implemented.	Review of four patients care records evidenced that this recommendation had been met.	Compliant
3	12.1	A recommendation has been made for a review of meals and meal times with regard to the quality, choice and timing of meals. Patients and/or their representatives should be consulted as part of this review.	Inspection of the report prepared follow the review of meals and meal times evidenced that this recommendation had been met. There was evidenced that patients and/or their representatives had been consulted as part of this review.	Compliant
4	20.2	It is recommended that emergency suction equipment is made available and appropriately maintained.	The inspector can confirm that this recommendation had been met.	Compliant

5	20.4	It is recommended that the first aider available on each shift has been clearly identified on the staff duty rota.	Inspection of four weeks staff duty rotas evidenced that this recommendation had been met.	Compliant
6	6.2	The registered manager must ensure that entries in care records are legible and maintained in accordance with NMC guidelines on record keeping.	Review of four patients care records evidenced that this recommendation had been met.	Compliant
7	17.10	The registered manager must ensure that records are kept of all complaints and these include details of all communication with complainants, the results of any investigations and the action taken.	Review of complaints records confirmed that this recommendation had been met.	Compliant

9.1 Follow- up on any issues /concerns raised with RQIA since the previous inspection such as complaints or safeguarding investigations.

Since the previous care inspection on 05 March 2014, RQIA have received no notification of safeguarding of vulnerable adult (SOVA) incidents in respect of Camphill Care Home.

11.0 Additional Areas Examined

11.1 Documents required to be held in the Nursing Home

Prior to the inspection a checklist of documents required to be held in the home under regulation 19(2) schedule 4 of The Nursing Homes Regulations (Northern Ireland) was forwarded to the home for completion. The evidence provided in the returned questionnaire confirmed that the required documents were maintained in the home and were available for inspection. The inspector reviewed the following records:

- The home's statement of purpose
- The patient's guide
- Sample of reports of unannounced visits to the home under regulation 29
- Sample of staff duty rosters
- Record of complaints
- Sample of incident/accidents
- Record of food provided for patients
- Statement of the procedure to be followed in the event of a fire
- Sample of the minutes of patients/relatives and staff meetings.

11.2 Patients under guardianship

Information regarding arrangements for any people who were subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) order 1986.

At the time of the inspection, and living in or using this service was sought as part of this inspection. During the inspection there were no patients in the home who were subject to a guardianship order.

11.3 Human Rights Act 1998 and European Convention on Human Rights (ECHR) DNSSPS and Deprivation of Liberty Safeguards (DOLS)

The inspector discussed the Human Rights Act and the Human Rights Legislation with the registered manager. The inspector can confirm that copies of these documents were available in the home.

11.4 Quality of interaction schedule (QUIS)

The inspector undertook a number of periods of observation in the home which lasted approximately 30 minutes each.

The inspector observed the patients' lunch meal which was served in the dining room. The inspector also observed a small number of patients having their lunch meal in the small day room.

The observation tool used to record these observations uses a simple coding system to record interactions between staff, patients and visitors.

Positive interactions	All positive
Basic care interactions	
Neutral interactions	
Negative interactions	

A description of the coding categories of the Quality of Interaction Tool is appended to the report at appendix 2.

The staff were observed seating the patients in preparation for their lunch in an unhurried manner.

The staff explained to the patients their menu choice and provided adequate support and supervision.

Observation of care practices during these periods of observation revealed that staff were respectful in their interactions with the patients.

Overall the periods of observations were positive.

11.5 Complaints

Prior to the inspection a complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. One compliant was recorded since the previous inspection this complaint was investigated appropriately.

11.6 Patient Finance Questionnaire

Prior to the inspection a patient questionnaire was forwarded by RQIA to the home for completion. The evidence provided in the returned questionnaire indicated that patients' monies were being managed in accordance with legislation and best practice guidance.

11.7 NMC declaration

Prior to the inspection the manager was asked to complete a proforma to confirm that all nurses employed were registered with the Nursing and Midwifery Council of the United Kingdom (NMC).

The evidence provided in the returned proforma indicated that all nurses, including the manager were registered with the NMC.

11.8 Staffing /Staff Comments

On the day of inspection the inspector examined staff duty rosters for four weeks. Inspection confirmed that registered nurses and care staff staffing levels for day and night duty were in accordance with the RQIA's recommended minimum staffing guidelines.

The inspector spoke to 20 staff members during the inspection process and reviewed three staff completed questionnaires.

Examples of staff comments were for as follows:

"I am content of the care provided in this home. Our residents are treated with respect and dignity by staff."

11.9 Patients' Comments

The inspector spoke to 30 patients individually and with others in groups. Five patients completed questionnaires were reviewed.

Examples of their comments were as follows:

"Everything is very good. I had a hearing aid but I lost if before I came into this home. I would like another as I am very hard of hearing."

"Staff here are excellent. I am waiting on an OT assessment for discharge home. This is a slow process. I would like this followed up, otherwise I couldn't find fault with the care here."

11. 10 Relatives' Comments

The inspector spoke to two relatives and reviewed two relative's completed questionnaires.

Examples of relatives' comments were as follows:

"The care is very good and staff are excellent. My mother is very happy here."

11.11 Environment

The inspector undertook an inspection of the home and viewed a number of patients' bedrooms, communal facilities and toilet and bathroom areas.

The home was clean, warm and comfortable. However there were a number of double glazing units which had moisture between the glasses. A requirement has been raised.

A requirement has also been stated for the second time with regard to the repair/replacement of damaged doors and architraves.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Dulce Amor Yanga-Ali (Acting Manager) as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider / manager is required to record comments on the Quality Improvement Plan.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Enquiries relating to this report should be addressed to:

Bridget Dougan
The Regulation and Quality Improvement Authority
Hilltop
Tyrone & Fermanagh Hospital
Omagh
BT79 0NS

Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
A Pre- Admisssion assessment is carried out on residents prior to admission to the home by the Home Manager or a designated other.The information is gathered from the resident, their representstive,care records and care manager. Where possible at this stage, risk assessments will also be completed. Following this, a decision is made as to whether the home can meet the residents assessed needs. In the case of an emergency admission where the home is unable to carry out a pre admission assessment, then an assessment is completed via telephone with written comprehensive mutlidisciplinary information faxed or left into the home. An admission will only take place where the Manager is satisfied that the home can meet the needs of the patient.	Compliant

On admission to the home, a Named Nurse completes initial assessments. This assessment is based on information gleamed from the resident/representative, pre admission assessment and information obtained from the care management team. Within 12hours of admission, an admission assessment, photography consent, personal belongings inventory, a record of 'my preferences' and a needs assessment which includes 16 areas of need is completed. Immediately on admission, risk assessments are completed to include a skin, wound, moving and handling, falls, risk, bed rail, pain, nutrition and oral. Within 7 days a continence and bowel assessment are completed. The above is also informed by resident/representative following which a care plan is developed to meet the residents assessed need.	
Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.**	

Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Within 7 days a Named Nurse completes a comprehensive assessment of the residents holistic care needs using assessment tools such as Braden, MUST etc as outlined in section A. The Named Nurse devises care plans to meet the patients assessed needs in consultation with the resident/representative. The care plans take into account the residents level of dependance and maximum independence will be promoted. Recommendations from the multidisciplinary team will also form part of the care plan. Nurses are aware of the process of referral to tissue viability when necessary. TheTissue Viability Nurse's details are held in the Nurse's office in order for a referral form to be sent. Referrals to TVN are followed up by a telephone call to obtain possible advice prior to a home visit. The same process will apply to residents who have lower limb or foot alceration where podiatry/TVN may be required. Where a patient is assessed at being at risk of developing pressure ulcers, a pressure ulcer management and treatment plan is commenced. A care plan will be devised to include skin care, frequency of repositioning, mattress type and setting. Recommendation made by other MDT members will be included in the care plan. The care plan is agreed with the resident/reprensentative. The Regional Manager is kept informed via a monthly report and during the REG29 visit. The Registered Nurse will make a decision to refer a resident to the dietician based on the MUST tool score and their clinical judgement. Dietician referral forms are held within the home and can be completed and faxed directly to the dietician. The Dietician can also be contacted by telephone for any advice prior to the home visit. All advice, treatment and recommendations are recorded on the MDT form with a care plan being devised to reflect this. The care plan is reviewed and evaluated on a monthly basis or more frequently if required.	Compliant

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The Needs Assessment, Care Plans and Risk Assessments are reviewd and evaulated once a month and as necessary as the resident's condition dictates. The Care Plan will outlinehow often it should be reviewed and re-assessed and this will be recorded on the plan of Care. Assessment take place on a daily basis and changes to the patient's condition are recorded on the daily progess notes and Care Plan evaluation forms. The Home Manager is also provided with a 24 hour shift report which identifies any changes. The Home Manager and Regional Manager complete audits to ensure that the above is carried out and action plans will be complied where a deficit is identified.	Compliant
Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.**	

Criterion 8.4 • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The Home has current guidelines set by professional bodies and national standard setting organisations as a reference guide when planning care, e.g NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA. The Home uses the EPUAP grading system as a tool to screen residents who have skin damage. If a resident is admitted to the home with a pressure ulcer or a pressure ulcer develops during admission then an intial wound assessment is completed with a plan of care which includes the grade of pressure ulcer, dressing regime, how to clean the wound, frequency of repositioning, type of mattress and time interval for review. An ongoing wound assessment and Care Plan evaluation is completed at each dressing change thereafter. If there is any change to the dressing regime or if the condition of the pressure ulcer changes, the Care Plan is adjusted to reflect this. Nutrional Guidance documents such as "Promoting good nutrition", RCN - "Nutrition now", "PHA - " Nutrional guidelines and Menu Checklist for Resdiential and Care Homes" and NICE guidelines - Nutrition Support in Adults are available for staff to refer to on an ongoing basis. Staff also refer to FSHC policies and procedures in relation to Nutrional Care, Diabetic Care, Care of Subcutaneous fluids and Care of Percutaneous Endoscopic Gastrostomy (PEG)	Compliant
Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.**	

Criterion 12.12 • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
As per NMC guidelines, Nurses keep contemporaneous records of all Nursing interventions, activites and procedures carried out with each resident. Nurses have access to policies and procedures relating to record keeping and also have their personal copies of the NMC guidance - Record Keeping Guidance for Nurses and Midwifes. Records of the meals provided for each resident at meal times are recorded on a daily menu choice form. The Catering Manager also keeps records of thefood served and includes any specialist dietary needs. Residents who are assessed as being at risk of malnutrition, dehydration or eating excessively have their food and fluid intake recorded daily using a FSHC Food/Fluid record booklet. The Resident's daily fluid intake is totalled at the end of a 24hour period. The Nurse uses this information to inform their daily evaluation. Any deficits are identified and appropriate action taken e.g referrals made to GP/Dietcian. Changes to the residents care plan is discussed with them/or their representative. Where care record audits identify any deficits , this will be addressed with nurses during supervision.	Compliant
Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The outcome of delivered care is monitored and recorded on a daily basis on daily progress notes with a minimum of one entry during the day and one at night. The outcome of care is reviewed as indicated on the plan of care or more frequent if there is a change in the resident,s condition or if there are recommendations made by a MDT member. Residents and/or their representatives are involved where possible in the evaluation process.	Compliant

Section G

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.

Criterion 5.8

- **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.**

Criterion 5.9

- **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.**

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Care Management reviews are usually carried out 6 - 8 weeks following admission and annually thereafter. Where a resident,s needs have changed , expressions of dissatisfaction with care delivered or at the request of the resident/representative a review can also be convened. The Trust will organise the review and invite the resident or their representative to attend. A nurse will also attend. The Care manager then sends a copy of the review minutes to the home and a copy is retained in the resident,s care file. Recommendations made are actioned by the home and care plan adjusted to reflect same. The resident or their representative is kept informed of the progress made towards agreed goals.	Compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The home adheres to FSHCpolicy and procedures in relation to nutrition and follows best practice guidance as outlined in section D. On admission, a nurse fully assesses the residents nutritional needs and reviews on an ongoing basis. The care plan outlines the type of diet required, risk of choking, any specific dietry needs, personal likes and dislikes, specilized equipment needed,assistance required and specific recommendations made by SALT and Dietician.The care plan is evaluated on a monthly basis and as required as the needs of the residents change. The home has a four week menu which is reviewed on a six monthly basis to include seasonal foods. The menu is informed by residents and their representatives during resident/ relatives meetings, food questionaires. The PHA document - "Nutritional and Menu Checklist for Residential and Nursing Homes" is used as a guide to ensure that the menu is varied and nutritious. The nurse provides the kitchen with a diet notification form and copies of the resident SALT and Dietician recommendations to keep catering staff informed of the resident,s needs.	Compliant

Residents are offered a choice of two meals/desserts at each meal time. If the resident does not wish to select from the menu provided an alternative meal of their choice is provided. Residents on therapeutic diets are also provided with the same opportunity to choose. The residents selected choice is recorded on a daily menu sheet. A variety of condiments, sauces and fluids are available at each meal. The daily menu is displayed in the dining room and the four weekly menu is displayed also for relatives and relatives to view.	
Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**

Registered nurses received training on enteral feeding and Dysphagia on 29/10/13. Further training on Dysphagia and feeding techniques all care and kitchen staff is arranged for 29/4/14 , 13/6/14 and 11/9/14. Informal advice is provided by Dietician and SALT when they visit the home. Nurses refer to guidance such as NICE guidelines - "Nutrition Support in Adults" and NPSA document - "Dysphagia Diet Food Texture Descriptors". Recommendations made by the SALT are included in the care plan to outline type of diet, fluid consistency, position for feeding and necessary equipment. The kitchen receives a copy of the SALT's recommendations for their own reference. Meals are served at the following times: Breakfast - 9.00am to 10.30am Morning Tea - 11.00am Lunch - 12.30pm - 1.00pm Afternoon Tea - 2.30pm Dinner - 4.30pm - 5.00pm. Supper - 8.15pm The above can be adjusted where residents request to have their meals at a different time. Hot and Cold drinks and a variety of snacks are available during the day and night and on residents request which conforms with all their dietary needs. Cold drinks including fresh water, are available at all times in the lounges and bedrooms and these are replenished on a regular basis. All residents care plans include their likes and dislikes, type of diet, fluid consistency, equipment required and assistance needed. A diet notification form is completed for each resident with a copy given to the kitchen and one retained in the care file. A member of staff is always present in the dining room during meal times. Residents who require supervision or assistance are given individual attention and are assisted at a pace suited to their needs. As indicated in the care plan, plate guards and specialised cutlery are available. All Nurses have completed E-Learning education on pressure area care. The home has a link Nurse who has received enhanced training to provide support to other Nurses within the home. Central training can also be arranged where Nurses feel they would benefit from this. All Nurses have a wound competency assessment completed.	Compliant

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	COMPLIANCE LEVEL
	Compliant

Appendix 2

Explanation of coding categories as referenced in the Quality of Interaction Schedule (QUIS)

Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.	**Basic Care: (BC) –** basic physical care e.g. bathing or use if toilet etc. with task carried out adequately but without the elements of social psychological support as above. It is the conversation necessary to get the task done.
• Staff actively engage with people e.g. what sort of night did you have, how do you feel this morning etc. (even if the person is unable to respond verbally) • Checking with people to see how they are and if they need anything • Encouragement and comfort during care tasks (moving and handling, walking, bathing etc.) that is more than necessary to carry out a task • Offering choice and actively seeking engagement and participation with patients • Explanations and offering information are tailored to the individual, the language used easy to understand ,and non-verbal used were appropriate • Smiling, laughing together, personal touch and empathy • Offering more food/ asking if finished, going the extra mile • Taking an interest in the older patient as a person, rather than just another admission • Staff treat people with respect addressing older patients and visitors respectfully, providing timely assistance and giving an explanation if unable to do something right away • Staff respect older people's privacy and dignity by speaking quietly with older people about private matters and by not talking about an individual's care in front of others	**Examples include:** Brief verbal explanations and encouragement, but only that the necessary to carry out the task No general conversation

Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.	**Negative (NS) –** communication which is disregarding of the residents' dignity and respect.

Examples include: • Putting plate down without verbal or non-verbal contact • Undirected greeting or comments to the room in general • Makes someone feel ill at ease and uncomfortable • Lacks caring or empathy but not necessarily overtly rude • Completion of care tasks such as checking readings, filling in charts without any verbal or non-verbal contact • Telling someone what is going to happen without offering choice or the opportunity to ask questions • Not showing interest in what the patient or visitor is saying	**Examples include:** • Ignoring, undermining, use of childlike language, talking over an older person during conversations • Being told to wait for attention without explanation or comfort • Told to do something without discussion, explanation or help offered • Being told can't have something without good reason/ explanation • Treating an older person in a childlike or disapproving way • Not allowing an older person to use their abilities or make choices (even if said with 'kindness') • Seeking choice but then ignoring or over ruling it • Being angry with or scolding older patients • Being rude and unfriendly • Bedside hand over not including the patient

References

QUIS originally developed by Dean, Proudfoot and Lindesay (1993). The quality of interactions schedule (QUIS): development, reliability and use in the evaluation of two domus units. *International Journal of Geriatric Psychiatry* Vol *pp 819-826.

QUIS tool guidance adapted from Everybody Matters: Sustaining Dignity in Care. London City University.

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Primary Inspection

Camphill Care Home

03 June 2014

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Ms Dulce Amor Yanga-Ali Acting Manager either during or after the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers/managers should note that failure to comply with regulations may lead to further enforcement and/or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider/manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on the HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and the Nursing Homes Regulations (NI) 2005

No.	Regulation Reference	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	27 (2) (b)	The registered person shall having regard to the number and needs of the patients, ensure that the premises to be used as the nursing home are of sound construction and kept in a good state of repair externally and internally. Doors and architraves were damaged throughout the home. These should be repaired/ replaced. **Reference: Section 9.0**	Two	From December 2013 a number of kick plates and architraves have been replaced or repaired on all stores, treatment rooms, sluices, lounges and the kitchen area	Within three months from date of inspection
2	27 (2) (b)	The registered person shall having regard to the number and needs of the patients, ensure that the premises to be used as the nursing home are of sound construction and kept in a good state of repair externally and internally. There was moisture between double glazing panels in a number of patients' bedrooms. . These should be repaired/ replaced. **Reference: Section 8.0**	One	The identified windows were replaced 13th August 2014	Within three months from date of inspection

Recommendations

These recommendations are based on the Nursing Homes Minimum Standards (2008), research or recognised sources. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	32.8	The registered person should submit to RQIA the timescales for completion of the work to repair/replace damaged doors and architraves. **Reference: Section 8.0**	One	Kick plates and architraves have been replaced or repaired on all stores, treatment rooms, sluices, lounges and the kitchen area. Maintenance person will continue to replace/repair any that are identified through a monitoring process	Within three weeks from receipt of this report
2	28.4	The registered person must ensure that care assistants receive a training update on the prevention of pressure ulcers. **Reference: Section 8.0**	One	Training commenced on 09/06/2014. More trainings will be arranged.E-Learning is also offered. Staff also encouraged to attend RCN course on same topic.	Within one month from date of receipt of this report

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person:

Name of Registered Manager Completing Qip	Dulce Amor Yanga-Ali
Name of Responsible Person / Identified Responsible Person Approving Qip	Jim McCall J P WATSON DIRECTOR OF OPERATIONS 19/8/2014.

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable			
Further information requested from provider			

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	Bridget Dougan	20 August 2014
Further information requested from provider			