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Unannounced Care Inspection
of
Camphill

7 October 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1. Summary of Inspection

An unannounced care inspection took place on 7 October 2015 from 09 50 to 15 50 hours.

This inspection was underpinned by **Standard 19 - Communicating Effectively; Standard 20 – Death and Dying and Standard 32 - Palliative and End of Life Care.**

On the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no significant areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 15 May 2015.

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**0**	**4**

The details of the Quality Improvement Plan (QIP) within this report were discussed with the registered manager Joy McKay and Patricia Greatbank, regional manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Four Seasons Health Care	**Registered Manager:** Joy McKay
Person in Charge of the Home at the Time of Inspection: Joy McKay	**Date Manager Registered:** 4 June 2015
Categories of Care: NH-MP(E), NH-I, NH-PH, NH-PH(E), NH-DE	**Number of Registered Places:** 72
Number of Patients Accommodated on Day of Inspection: 49	**Weekly Tariff at Time of Inspection:** £593.00 - £637.00

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standards and theme have been met:

Standard 19: Communicating Effectively
Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

4. Methods/Process

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

- discussion with registered manager
- discussion with the regional manager
- discussion with staff
- discussion with patients
- discussion with relatives
- review of records
- observation during a tour of the premises
- evaluation and feedback

Prior to inspection the following records were analysed:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the previous care inspection report

During the inspection, the inspector met with eight patients individually and with the majority generally, five care staff, seven registered nurses and three patient's visitors/representative.

The following records were examined during the inspection:

- care records of eight patients
- policies and procedures
- record of complaints and compliments
- staff training records

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced finance inspection dated 28 July 2015. The completed QIP was returned and approved by the finance inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 4, criteria 1 **Stated:** First time	It is recommended that care plans for the management of continence should be further developed to include: • the specific type of continence aids required • the frequency with which catheters require to be changed	**Met**
	Action taken as confirmed during the inspection: Care records reviewed contained the specific type of continence aids required and the frequency with which catheters require to be changed. This recommendation has been met.	
Recommendation 2 **Ref**: Standard 39, criteria 8 **Stated:** First time	It is recommended that the care plans which were illegible should be rewritten as a matter of urgency and registered nurses reminded that all care records must be legible.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that the identified records had been rewritten. Care records reviewed were all legible. This recommendation had been met.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy was available on communicating effectively. A copy of the DHSSPS regional guidance on breaking bad news was available in the home.

A sample of training records evidenced that staff had not completed formal training in relation to communicating effectively with patients and their families/representatives. However, discussion with the registered manager, registered nurses and care staff confirmed that staff were aware of the sensitivities around breaking bad news and the importance of accurate and effective communication.

Is Care Effective? (Quality of Management)

Care records made reference to the patients' specific communication needs including sensory and cognitive impairment. There was evidence within the care records that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs.

Patients' relatives confirmed that they were kept informed of any changes to their relative's condition and of the outcome of visits and reviews by healthcare professionals. However through discussion with one family it became clear that whilst staff had informed them of referrals to health care professionals the family were unsure of the plan of care or what the next steps were. There were no records of communication with the family. A recommendation was made.

The registered manager and two registered nurses demonstrated their ability to communicate sensitively with patients and relatives when breaking bad news and provided examples of how they had done this in the past.

Care staff considered the breaking of bad news to be the responsibility of the registered nursing staff but felt confident that, should a patient or relatives choose to talk to them about a diagnosis or prognosis of illness, they would have the necessary skills to do so.

Is Care Compassionate? (Quality of Care)

Observations of the delivery of care and staff interactions with patients confirmed that communication was well maintained and patients were observed to be treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time.

Discussion with eight patients individually and with the majority of patients generally evidenced that patients were content living in the home.

Areas for Improvement

Staff should ensure that information has been communicated effectively and the relatives understand the information given to them. Records should be maintained of all communication to relatives.

Number of Requirements:	**0**	**Number of Recommendations**:	**1**

5.4 Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

Is Care Safe? (Quality of Life)

Policies and procedures on the management of palliative, end of life care and death and dying were held in the Palliative and End of Life Care Manual which was available in the home in draft form. These documents were currently under review by Four Seasons Health Care to ensure that they were reflective of best practice guidance such as Guidelines and Audit

Implementation Network (GAIN) Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes, December 2013. A recommendation has been made.

A copy of the GAIN Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes, December 2013 was available in the home for staff.

A policy and procedure on the management of death and dying was available and reflected best practice guidance. The management of the deceased person's belongings and personal effects was included in the policy and procedure. Staff spoken with were knowledgeable of the procedure and who had responsibility for ensuring the deceased person's belongings were treated with respected.

There were no registered nurses identified as link workers in palliative care. The allocation of link nurses was discussed with the registered manager who confirmed that there were link nurses for areas such as continence within the home. The benefits of link nurses were discussed and the registered manager agreed to identify staff. A recommendation has been made.

Training records evidenced that 15 staff had received training in palliative and end of life care on 17 August 2015.

The registered manager confirmed that support to manage syringe drivers was provided by district nursing within the local health and social care trust.

Is Care Effective? (Quality of Management)

Review of care records and discussion with the registered manager and registered nurse evidenced that death and dying arrangements were included as part of the needs assessment completed for each patient. Of the eight care records reviewed only one contained specific details of the patients' assessed needs or wishes with regard to end of life care. Generally examples of comments recorded in the section entitled "Palliative and end of life needs" included:

"has DNAR in place, no end of life needs identified"
"none discussed."
"DNAR signed".

The registered manager and registered nurse recognised that, whilst some discussion had taken place regarding the wishes of patients and relatives with the DNAR directives, there was a need to create further opportunities to discuss end of life care in greater detail; in particular in the event of patients becoming suddenly unwell.

Whilst the inspector acknowledged that there may be occasions when patients and/or their relatives do not wish to discuss end of life care, opportunities to prompt discussion, should be created by the registered nurses and any expressed wishes of patients and/or their representatives formulated into a care plan for end of life care. A recommendation was made.

Discussion with a registered nurse and four care staff evidenced that environmental factors, which had the potential to impact on patient privacy had been considered. Staff confirmed that facilities were made available for family members to spend extended periods with their loved

ones during the final days of life. Meals, snacks and emotional support were provided by the staff team.

A review of notifications of death to RQIA during the previous inspection year evidenced that these were reported appropriately.

Is Care Compassionate? (Quality of Care)

The religious, spiritual or cultural need of the patients had been identified but there was no evidence of consideration of these areas in respect of end of life care. Discussion with patients and staff evidenced that arrangements were in place on a day to day basis to meet patients' religious and spiritual needs.

Arrangements were in place to facilitate family and friends to spend as much time as they wish with the patient who was ill or dying. Staff discussed openly a number of recent deaths and how the home had been able to support the family members in providing refreshments and facilitating staying overnight with their loved ones.

From discussion with the registered manager, six staff and a review of the compliments record, there was evidence that there were sound arrangements to support relatives during this time. Numerous compliments had been received by the home from relatives and friends of former patients. The following are some comments recorded in thank you cards received:

"…appreciation for the care and kindness shown to our mum …in the last few months. Thanks for the many cups of tea and biscuits."

"A big thank you for all who cared so well for our dad. We so appreciate all you did for him in the last 3 weeks and over the years."

"Camphill was mum's home from home. Thank you for kindness and care for her and dad over the past three years."

Areas for Improvement

To ensure that staff knowledge and care delivery is reflective of best practice in palliative and end of life care it was recommended that when the updated Palliative and end of life care manual is issued by Four Seasons Health Care that staff receive an induction/training on the content.

Link nurses, and if appropriate carers, for palliative and end of life care should be identified and provided with enhanced training to act as resource within the home to guide, inform and support patients, relatives and staff.

Further opportunities, to discuss end of life care, should be created by the registered nurses. Any expressed wishes of patients and/or their representatives should be formulated into a care plan for end of life care. This should include any wishes with regard to the religious, spiritual or cultural need of patients'.

Number of Requirements:	**0**	**Number of Recommendations:**	**3**

5.5 Additional Areas Examined

5.5.1. Consultation with patients, their representatives and staff.

Discussion took place with 8 patients individually and with the majority of patients in smaller groups. Comments from patients regarding the quality of care, food and in general the life in the home were positive. Examples of comments received are:

“Very friendly, hardworking staff.”

“They can’t do enough for you.”

“Very happy here.”

There were no issues or concerns raised by patients.

Three patients’ representatives confirmed that they were happy with care delivery and staffing in the home. As previously discussed the need for further communication with one family was identified. Ten questionnaires were issued to patients’ relatives; one was returned prior to the end of the inspection and three were returned by post. All of the respondents indicated that they were very satisfied that the care in the home was safe effective and compassionate.

Comments included:

“All the staff treat my mother with dignity and respect and all the visitors.”

“Staff are very friendly and courteous. Trained staff are approachable and have time to listen to you.”

“I come in daily to visit mum the staff are always very friendly and quick to let me know if mum is not feeling well”

“I think they do a great job at keeping the residents entertained i.e. baking, craft, games days.”

One relative commented that they would like to see more staff on duty. However other comments evidenced that they were very satisfied with the care their relative was receiving.

Staff commented positively with regard to staffing and the delivery of care. Staff were knowledgeable regarding their patient’s needs, wishes and preferences.

Ten questionnaires were issued to nursing, care and ancillary staff. Two were returned. Staff indicated that they were very satisfied or satisfied that care was safe, effective and compassionate. One staff member commented that more care staff were needed. This opinion was not substantiated in the findings of the inspection.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with registered manager Joy McKay and Patricia Greatbank, regional manager as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person/manager to ensure that all requirements and recommendations contained within the QIP 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.

6.1 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 (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Care Standards for Nursing Homes, April 2015. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that any requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Recommendations	
Recommendation 1 **Ref**: Standard 19.4 **Stated:** First time **To be Completed by:** 4 November 2015	It is recommended that staff check peoples understanding of the information given to them and provide regular updates to ensure that communication is effective. Records should be maintained of communication with relatives.
	Response by Registered Person(s) Detailing the Actions Taken: The trained staff have been informed to update the families on a regular basis making sure that they understand the information passed onto them. Accordingly the communication record in the resident's care file is completed with the relevant details. This will be discussed further at the next trained staff meeting in November.
Recommendation 2 **Ref**: Standard 36.2 **Stated:** First time **To be Completed by:** 18 November 2015	It is recommended that when the updated palliative and end of life care manual is issued by Four Seasons Health Care that staff receive an induction/training on the content to ensure that staff knowledge and care delivery is reflective of best practice in palliative and end of life care.
	Response by Registered Person(s) Detailing the Actions Taken: The updated palliative and end of life care manual is now available. This is being introduced to the care staff so that they are aware of the contents ensuring that it informs the care delivered and reflects best practice guidelines.
Recommendation 3 **Ref**: Standard 32 **Stated:** First time **To be Completed by:** 18 November 2015	It is recommended that link nurses, and if appropriate carers, for palliative and end of life care should be identified and provided with enhanced training to act as a resource within the home to guide, inform and support patients, relatives and staff.
	Response by Registered Person(s) Detailing the Actions Taken: A link nurse for palliative / end of life care has been identified within the home who will act as a resource, advising and supporting residents, relatives and staff.
Recommendation 4 **Ref**: Standard 20.2 **Stated:** First time **To be Completed by:** 18 November 2015	It is recommended that further opportunities, to discuss end of life care, are considered and created by the registered nurses. Any expressed wishes of patients and/or their representatives should be formulated into a care plan for end of life care. This should include any wishes with regard to the religious, spiritual or cultural need of patients'.
	Response by Registered Person(s) Detailing the Actions Taken: This has been discussed with the trained staff to take any opportunity with the families to discuss end of life care and any wishes that they or their loved one may have. This will be discussed further at the next trained staff meeting in November.

Registered Manager Completing QIP	Joy McKay	**Date Completed**	05/11/15
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	06.11.15
RQIA Inspector Assessing Response	Sharon McKnight	**Date Approved**	9-11-15

Please ensure this document is completed in full and returned to Nursing.Team@rqia.org.uk from the authorised email address