Unannounced Care Inspection Report
10 May 2016

Camphill

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Tel No: 0282565 8999
Inspector: Sharon McKnight

1.0 Summary

An unannounced inspection of Camphill took place on 10 May 2016 from 09:50 hours to 17:10 hours.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies and staff training and development. Through discussion with staff we were assured that they were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding. A general inspection of the home confirmed that the premises and grounds were well maintained.

One area of improvement was identified with the records to evidence that staff who transfer from other FSHC homes have a structured orientation and induction to their new place of work. A recommendation was stated.

Is care effective?

Evidenced gathered during this inspection confirmed that there were systems and processes in place to ensure that the outcome of care delivery was positive for patients. A review of care records confirmed that patients were comprehensively assessed and care plans created to prescribe care. There were arrangements in place to monitor and review the effectiveness of care delivery. We examined the systems in place to promote effective communication between staff, patients and relatives and were assured that these systems were effective. Patients, relatives and staff were of the opinion that the care delivered provided positive outcomes.

One areas of improvement was identified regarding the displaying of patient information. A recommendation was stated.

Is care compassionate?

Observations of care delivery evidenced that patients were treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully. Staff were also observed to be taking time to reassure patients as was required from time to time. Systems were in place to ensure that patients, and relatives, were involved and communicated with regarding day to day issues affecting them. Patients spoken with commented positively in regard to the care they received.

There were no areas of improvement identified in the delivery of compassionate care.

Is the service well led?

There was evidence of good leadership in the home and effective governance arrangements. Staff spoken with were knowledgeable regarding the line management structure within the home and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. There were systems in place to monitor the quality of the services delivered.

There were no areas of improvement identified in the domain of well led.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**0**	**2**

Details of the QIP within this report were discussed with Ms Anne O'Kane, manager and Ms Louisa Rea, regional manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection. Other than those actions detailed in the previous QIP there were no further actions required.

RQIA have also reviewed any evidence available in respect of serious adverse incidents, potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare Maureen Claire Royston	**Registered manager:** Ms O'Kane's application for registered manager is currently being processed.
Person in charge of the home at the time of inspection: Anne O'Kane	**Date manager registered:** RQIA were notified on 12 April 2016 of Ms O'Kane's appointment to the position of manager.
Categories of care: NH-MP(E), NH-I, NH-PH, NH-PH(E), NH-DE	**Number of registered places:** 72

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report

During the inspection the inspector met with fifteen patients, the deputy manager, nursing sister, charge nurse, one registered nurses, one supervised practice nurse, five care staff, the housekeeper, a catering assistant and three patients' relatives.

The following information was examined during the inspection:

- five patient care records
- staff duty roster for the week commencing 9 May 2016
- staff training records
- staff induction records
- staff competency and capability assessments
- staff recruitment records
- complaints and compliments records
- incident and accident records
- records of audit
- records of staff meetings
- reports of monthly visits undertaken in accordance with Regulation 29

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 7 October 2015.

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and will be validated during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 9 October 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 19.4 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Details of communication with families were recorded in the patient's care records. No further issues with misunderstanding have been identified since the previous inspection. This recommendation has been met.	
Recommendation 2 **Ref**: Standard 36.2 **Stated:** First time	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.	**Partially Met**
	Action taken as confirmed during the inspection: The most recent issue of the palliative and end of life care manual was available in the home. A sheet for staff to sign and confirm their awareness of the manual was available in the file. There was evidenced that staff had signed to confirm their awareness. Following discussion it was agreed that the manager will ensure that all staff are made aware of the manual. This recommendation is assessed as partially met. Given the assurances provided by the manager there will be no further review of this recommendation.	

Recommendation 3 **Ref**: Standard 32 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: The manager confirmed that a link nurse had been identified for palliative and end of life care. Discussion with the link nurse evidenced that they have attended training delivered by the Royal College of Nursing (RCN). Further training opportunities have been identified. This recommendation has been met.	
Recommendation 4 **Ref**: Standard 20.2 **Stated:** First time	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'.	**Met**
	Action taken as confirmed during the inspection: A review of three patients' care records evidenced that this recommendation has been addressed.	

4.3 Is care safe?

The manager confirmed the current occupancy of the home and the planned daily staffing levels. They advised that these levels were subject to regular review to ensure the assessed needs of the patients were met.

A review of the staffing roster for week commencing 9 May 2016 evidenced that the planned staffing levels were adhered to. In addition to nursing and care staff, staffing rosters confirmed that administrative, catering, domestic, laundry and maintenance staff were on duty daily. Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. Patients commented positively regarding the staff and care delivery.

The manager and registered nurses spoken with were aware of who was in charge of the home when the manager was off duty. The nurse in charge on day and night duty was clearly identified on the staffing roster.

Discussion with four registered nurses who were given the responsibility of being in charge of the home in the absence of the manager confirmed that they had been given the relevant information to undertake the role and were knowledgeable regarding management situations.

The registered nurses confirmed that a competency and capability assessment had been completed with them. Records of these assessments were not reviewed on this occasion.

Discussion with the manager and a review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff were appropriately managed. The manager was knowledgeable regarding the management of the Northern Ireland Social Care Council (NISCC) registration process for newly employed care staff.

A review of one personnel file evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. The record maintained of Access NI checks was reviewed and evidenced that the certificate had been checked prior to the candidate commencing employment.

The manager and staff confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

Discussion with the manager and staff and a review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. One completed induction programme was reviewed. The programme included a written record of the areas completed and the signature of the staff member and the person supporting the new employee. The induction programme had not been signed by the previous registered manager. The current manager was aware that induction records should be signed by the manager to confirm that the induction process had been satisfactorily completed.

We discussed the induction of a staff member who had recently transferred from another home within Four Seasons Health Care (FSHC). No record of an induction to Camphill had been maintained. This was discussed with the manager who explained that the identified staff had transferred from the home they had previously managed where a full induction programme had been completed and recorded at the time of commencement of employment. The manager confirmed that the staff member had worked supernumerary for a period in Camphill in accordance with FSHC induction procedure. Following discussion with the manager it was agreed that all staff, including those who transfer from other FSHC homes should have a record of their structured orientation and induction retained. A recommendation was stated.

Training was available via an e learning system and internal face to face training arranged by FSHC. Training opportunities were also provided by the local health and social care trust and external agencies such as The Royal College of Nursing (RCN). The manager had systems in place to monitor staff attendance and compliance with training. These systems included a print out of which staff had completed an e learning training and signing in sheets to evidence which staff had attended face to face training in the home. A review of the print out of mandatory training evidenced good compliance with mandatory training; for example 97% of staff had completed adult safeguarding training, 89% fire safety and 97% infection prevention and control in the past 12 months. Training on dementia distressed reaction was attended by 6 staff on 8 April 2016.

The manager confirmed that systems were in place for staff supervision. Records to evidence the frequency supervision took place and the areas/topics were available; the content was not reviewed as part of the inspection.

The manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. The registered nurses, care staff and domestic staff were aware of whom to report concerns to within the home. Annual refresher training was considered mandatory by the home. The contact details of the adult safeguarding teams for the local healthcare trust was displayed in the nursing office of the general nursing unit.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process to accurately identify risk and inform the patient's individual care plans.

Discussion with the manager and a review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to the relevant bodies. A random selection of accidents and incidents recorded since the previous inspection evidenced that accidents and incidents had been appropriately notified to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. The manager completed a monthly analysis of falls to identify any trends or patterns.

A general inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. The home was fresh smelling, clean and appropriately heated. The designated smoking room in one unit was closed on the day of the inspection due to ongoing work. Temporary arrangements were in place for those patients who smoked. Confirmation that the work had been completed was received by electronic mail on 12 May 2016.

Fire exits and corridors were observed to be clear of clutter and obstruction.

There were no issues identified with infection prevention and control practice.

Areas for improvement

Staff who transfer from other FSHC homes should have a record retained of their structured orientation and induction to their new place of work.

Number of requirements	**0**	**Number of recommendations**:	**1**

4.4 Is care effective?

A review of three patient care records evidenced that initial plans of care were based on the pre admission assessment and referral information. A comprehensive, holistic assessment of patients' nursing needs was commenced at the time of admission to the home. As previously discussed a range of validated risk assessments were completed as part of the admission process.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) and dieticians. Care records were regularly reviewed and updated, as required, in response to patient need. Patient confidentiality in relation to the storage of records was maintained; however it was recommended that patient information displayed in the nursing offices was reviewed, and adjusted as required, to ensure that patient confidentiality and dignity was not compromised.

There was evidence within the care records that patients and/or their representatives were involved in the care planning process. There was also evidence of regular, ongoing communication with relatives. Registered nurses spoken with confirmed that care management reviews were arranged by the relevant health and social care trust. These reviews were generally held annually but could be requested at any time by the patient, their family or the home.

Discussion with the manager and staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

The manager confirmed that they planned to hold staff meetings regularly. Initial meetings were held by the manager on 1 April 2016 with nurses and care staff. A record of staff who had attended and issue discussed was available. Records were also available of staff meetings held by the previous registered manager. The signatures of the staff who attended were recorded.

Staff advised that there was effective teamwork; each staff member knew their role, function and responsibilities. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Staff also confirmed that if they had any concerns, they would raise these with the deputy manager, nursing sister or charge nurse in the first instance in keeping with the line management structure in the home.

Ten relative questionnaires were issued; three were returned prior to the issue of this report. The respondents indicated that they were very satisfied or satisfied with the delivery of safe, effective and compassionate care and that the service was well led .

Ten questionnaires were issued to nursing, care and ancillary staff; four were returned prior to the issue of this report. All of the respondents indicated that they were satisfied or very satisfied with the care delivery in the home.

Areas for improvement

Patient information displayed in the nursing offices should be reviewed, and adjusted as required, to ensure that patient confidentiality and dignity is not compromised.

Number of requirements	0	Number of recommendations:	1

4.5 Is care compassionate?

Observations throughout the inspection evidenced that there was a calm atmosphere in the home and staff were quietly attending to the patients' needs.

Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. We observed numerous occasions when staff offered patients' choice and took time to find out what the patients wanted when it was not always apparent and patients were unable to express their wishes clearly. 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. Staff spoken with were knowledgeable regarding patients likes and dislikes and individual preferences.

Patients spoken with commented positively in regard to the care they received. Those patients who were unable to verbally express their views were observed to be appropriately dressed and were relaxed and comfortable in their surroundings. Observation of care delivery confirmed that patients were assisted appropriately, with dignity and respect, and in a timely manner.

On the morning of the inspection there was a church service held for patients and relatives. Staff confirmed that these took place weekly and that the location was alternated weekly between units. Staff explained that a relative had been instrumental in establishing this weekly activity.

Relatives spoken with confirmed that they were made to feel welcome into the home by all staff. They were confident that if they raised a concern or query with the manager or staff, their concern would be addressed appropriately. The following comments were provided:
"very happy with the care now he is back in the home."
"They're just great, the best home in Northern Ireland."

The serving of lunch was observed in the general nursing unit. Tables were set with cutlery, condiments and napkins. Those patients who had their lunch in the lounge or bedroom were served their meal on a tray which was set with cutlery and condiments and the food was covered prior to leaving the dining room.

Meals were transported from the kitchen in heated trolleys and served by the kitchen staff; this left the registered nurses and care staff free to attend to the nutritional needs of the patients.

The serving of the lunch was observed to be well organised with all of the patients being attended to in a timely manner. The meals were nicely presented and smelt appetising. All of the patients spoken with enjoyed their lunch.

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:

“Heartfelt and sincere thanks for everything you did for…”

“You all cared for her with such great compassion and dignity, and we truly appreciate the times some of you sat with her during your lunch and tea breaks.”

Areas for improvement

No areas for improvement were identified in the delivery of compassionate care

Number of requirements	**0**	**Number of recommendations**:	**0**

4.6 Is the service well led?

The certificate of registration issued by RQIA and the home’s certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered. The Statement of Purpose and Patient Guide were available in the home.

Staff spoken with were knowledgeable regarding line management and who they would escalate any issues or concerns to; this included the reporting arrangements when the manager was off duty. Discussions with staff acknowledged that the manager had recently been appointed to the home; staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Patients and representatives spoken with confirmed that they were aware of the home’s complaints procedure; they were confident that staff and /or management would address any concern raised by them appropriately. Patients were aware of who the registered manager was.

The complaints procedure was clearly displayed in the home. A record of complaints was maintained. The record included the date the complaint was received, the nature of the complaint, details of the investigation and a copy of the letter sent to the complainant. The record also indicated how it was concluded that the complaint was closed. An allegation of theft had been recorded in the complaints record; this was prior to the commencement of the current manager. The allegation had been reported to the relevant health and social care trust but had not been notified to RQIA as required under Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. We were assured by discussion with the current manager that they were knowledgeable regarding what incidents were required to be notify in accordance with Regulation 30.

An annual quality report was last completed on 30 September 2014. The manager explained that they were currently working on a report for the period 1 April 2015 to 31 March 2016. A copy of the annual report will be made available for patients and their relatives on completion.

The manager discussed the systems she had in place to monitor the quality of the services delivered and explained that a programme of audits had been commenced on a monthly basis.

Areas for audit included the dining experience, care records and falls. A review of the completed audits for care records evidenced that where an area for improvement was identified there was evidence of re-audit to check the necessary improvements had been made.

There were numerous thank you cards and letters received from former patients and relatives; examples of these have been included in the previous domain.

There were arrangements in place to receive and act on health and safety information, urgent communications, safety alerts and notices; for example from the Northern Ireland Adverse Incident Centre (NIAIC).

The unannounced monthly visits required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 were completed in accordance with the regulations. A copy of the report was maintained and available in the home; the report included an action plan to address any identified areas for improvement. There was evidence in the reports from February 2016 the action plans were reviewed during the next visit.

It was observed that the manager had robust systems to ensure they had oversight of the governance systems in the home. The manager spoke of the necessity of staff having access to all relevant information in her absence. Files were observed to be well organised, clearly labelled and easy to access. The manager's organisational skills and record management were commended during the inspection.

The manager has been in post from 12 April 2016. At the time of the inspection no application for registered manager has been received by RQIA. This was discussed with the regional manager and the manager at the conclusion of the inspection. An application for registered manager has now been received and is being processed.

Areas for improvement

No areas for improvement were identified within the domain of well led.

Number of requirements	**0**	**Number of recommendations**:	**0**

5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Louisa Rea, regional manager and Ms Anne O'Kane, 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the 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 by the registered manager. 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 areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered person/manager from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered person/manager with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 39.1 **Stated:** First time **To be completed by:** 7 May 2016	It is recommended that staff who transfer from other FSHC homes should have a record retained of their structured orientation and induction to their new place of work **Response by registered person detailing the actions taken:** This has been completed and will be implemented for all staff transfering going forward.
Recommendation 2 **Ref**: Standard 35.6 **Stated:** First time **To be completed by:** 7 May 2016	It is recommended that patient information displayed in the nursing offices is reviewed and adjusted as required, to ensure that patient confidentiality and dignity is not compromised. **Response by registered person detailing the actions taken:** Resident information displayed has been adapted to ensure confidentiality and dignity is maintained.

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

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