Unannounced Care Inspection Report
2 June 2016

Copperfields

Type of Service: Nursing Home
Address: 1-3 Moore Street, Augnhacloy, BT69 6AX
Tel No: 028 8555 7922
Inspector: Sharon Loane

1.0 Summary

An unannounced inspection of Copperfields took place on 2 June 2016 from 10.30 to 15.00 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.

For the purposes of this report, the term “patients” will be used to describe those living in Copperfield’s Nursing Home which provides both nursing and residential care.

Is care safe?

There was evidenced of competent delivery of care with positive outcomes for patients.

Review of records evidenced that planned staffing levels were adhered to; and discussion with patients, representatives and staff evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients’ needs were met by the levels and skill mix of staff on duty.

The registered manager and staff spoken with demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibilities in general and specifically in relation to adult safeguarding. Staff described their role and responsibilities with enthusiasm and said that they were enabled to ‘make a difference’.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

There were no areas for improvement identified.

Is care effective?

It was evident that care was effectively managed and delivered with positive outcomes for patients. For example, care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. Registered nurses assessed planned, evaluated and reviewed care in accordance with NMC guidelines.

All patients and relatives spoken with commented positively regarding the care they received and the staffs caring and kind attitude.

Staff stated that there was “effective teamwork”; this was also evidenced through discussion and observation of interactions throughout the inspection process.

One recommendation was made in regards to monitoring the registration of care staff with the Northern Ireland Social Care Council (NISCC).

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

There was evidence of outstanding delivery of compassionate care in relation to palliative and end of life care and in working with patients to make improvements in the home.

There were no areas for improvement identified.

Is the service well led?

There was evidence that overall systems and processes were in place and effectively managed to ensure the delivery of safe, effective and compassionate care. A recommendation has been made to ensure that audits are completed in a more systematic manner and any identified actions or improvements are re-audited to ensure that the required actions have been taken and are effective. Discussion with the registered manager and a review of records evidenced that systems were in place to ensure that notifiable events, complaints, and/or potential adult safeguarding concerns were investigated and reported to RQIA or other relevant bodies appropriately.

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 Quality Improvement Plan (QIP) within this report were discussed with Henry Edwards, registered person and Cherith McKeown, registered 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 announced estates inspection undertaken on 17 May 2016. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistleblowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Edwards Enterprises NI Ltd Mr William Henry Hume Edwards	**Registered manager:** Cherith McKeown
Person in charge of the home at the time of inspection: Cherith McKeown	**Date manager registered:** 1 April 2005
Categories of care: NH-LD, NH-LD(E), RC-I, NH-DE, NH-I There shall be a maximum of 8 patients accommodated within category NH-DE and a maximum of 2 patients accommodated within category NH-LD/LD(E). The home is also approved to provide care on a day basis for 1 person.	**Number of registered places:** 32

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 we met with eight patients individually and with the majority of others in smaller groups, two registered nurses, two care staff, two relatives and two healthcare professionals. Ten questionnaires were also issued to relatives and staff and five to patients with a request that they would be returned within one week of the date of inspection.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- three patient care records
- staff duty roster
- staff recruitment records
- staff induction records
- staff training records
- staff competency and capability assessments
- complaints record
- accident and incident records
- a selection of quality audit records
- records of staff, relative and patient meetings
- reports of monthly monitoring visits undertaken in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 17 May 2016

The most recent inspection of the home was an announced estates inspection. The QIP has been issued at time of writing this report and is due to be returned by 1 July 2016.

4.2 Review of requirements and recommendations from the last care inspection dated 10 June 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 39 **Stated:** First time	It is recommended that staff induction records include reference to the following; 1. Communication skills to include the breaking of bad news.	**Met**
	Action taken as confirmed during the inspection: A review of staff induction records evidenced that this element of care practice had been incorporated into the induction template. This recommendation has been met.	

Recommendation 2 **Ref:** Standard 39 **Stated**: First time	It is recommended that all staff receive training in keeping with their roles and responsibilities in the following; 1. Palliative care and care of the dying patient 2. Communication including the breaking of bad news.	**Met**
	Action taken as confirmed during the inspection: The registered manager advised that a number of registered nurses had attended training in the areas outlined in the recommendation. Additional training sessions have been organised for other staff in line with their roles and responsibilities. This recommendation has been met.	
Recommendation 3 **Ref:** Standard 20.2 **Stated**: First time	It is recommended that end of life care and patient's wishes in regards to their religious/spiritual wishes are discussed and outcomes documented in their care plan.	**Met**
	Action taken as confirmed during the inspection: A review of care records evidenced that care plans pertaining to end of life care had been developed since the last inspection. Furthermore, a discussion with a relative who had recently experienced the loss of a loved one, who had been a patient within the home, commended the management and staff for their care, guidance and support given during the final stage of life. They advised that the registered manager had discussed all aspects of care and personal wishes and that these had been carried out with utmost compassion and respect. This recommendation has been met.	

Recommendation 4 **Ref:** Standard 33.2 **Stated :** First time	It is recommended that a protocol should be developed for timely access to any specialist equipment or drugs which may be necessary to deliver end of life care including weekends and out of hours.	**Met**
	Action taken as confirmed during the inspection: A protocol has been developed and was available at this inspection. This recommendation has been met.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for week commencing 30 May 2016 evidenced that the planned staffing levels were adhered to. The staffing rota clearly identified the nurse in charge in the registered manager's absence, hours worked by the registered manager on the floor were identified and the rota was signed off by the registered manager at the end of each working week. Discussion with patients, representatives and staff evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

A review of one recruitment file evidenced that recruitment processes were in keeping with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. New staff were supported by the registered manager and were assigned a mentor. Review of one staff member's induction record evidenced that the record had been completed in full and was signed by the staff member, mentor and the registered manager.

Review of the training planner for 2016 indicated that training was planned to ensure that mandatory training requirements were met. Staff confirmed that they were required to attend mandatory training and if they failed to attend they would be spoken with both by the registered manager and registered person. A review of records for training completed during 2015 indicated that mandatory training requirements had been met by the majority of staff.

The registered manager and staff spoken with clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibilities. Staff described their role and responsibilities with enthusiasm and commitment and some of the staff spoken with had worked in the home for fifteen years plus. This is commended.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC). The registered manager advised that the checks are completed prior to commencing employment and are subsequently checked by the home's administrator on a monthly basis and the record of checks undertaken is then approved by the registered manager.

There was no system in place to evidence that the registration status of care staff with the Northern Ireland Social Care Council (NISCC) was monitored on a regular basis. The registered manager advised that the home was notified by NISCC of staff who had not renewed their registration and appropriate actions were taken. Whilst this information was acknowledged, a system should be developed to evidence the registration status of care staff with NISCC. A recommendation has been made.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. The registered nurses and care staff were knowledgeable of the procedure and protocol in place for reporting any concerns in relation to potential adult safeguarding concerns.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

A review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the last care inspection, July 2015 confirmed that these were managed appropriately.

A general inspection of the homes environment was undertaken to examine a random sample of bedrooms, bathrooms, and lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and exceptionally clean throughout with a notable "homely" ambience. Since the last care inspection, it was very evident that a number of patients' bedrooms had been refurbished and the registered manager advised that patients had been involved in choosing their colour scheme and soft furnishings.

There was also evidenced that there was work being carried out in regards to the exterior and the grounds of the home to include; paving and landscaping of the grounds and garden areas. These improvement works are commended and will further enhance the character of this home. Patients, their representatives and staff spoken with were complimentary in respect of the home's environment.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Areas for improvement

A system should be developed to monitor the registration status of care staff with the Northern Ireland Social Care Council. A recommendation has been made.

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

4.4 Is care effective?

A review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Risk assessments informed the care planning process and both were generally reviewed and updated on a monthly basis. Registered nurses assessed planned, evaluated and reviewed care in accordance with NMC guidelines.

Care records accurately reflected that were appropriate referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians and any recommendations made were adhered to.

Supplementary care charts such as repositioning/food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

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.

Staff confirmed that they were kept informed of changes or concerns regarding patients' needs by attending the handover reports at the beginning of each shift. A review of the duty rota evidenced the time for the handover report and identified which staff had to attend. The staff that attended then disseminated the necessary information to their colleagues.

Discussion with the registered manager confirmed that staff meetings were held on a quarterly basis and records were maintained. A number of meetings had occurred since the last care inspection and records evidenced the list of attendees, agenda and the minutes of the previous meeting held were discussed. The minutes also referred to Regulation 29 Monitoring visits completed by the registered person. Staff advised that they were very comfortable discussing issues with management and stated that both the registered person and manager were "always available" and very "approachable".

Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/management. Patients and representatives advised that the registered person and manager were always available to them and were very visible in the home.

A number of patients and their representatives were spoken with who commented positively regarding the staff, general care and the atmosphere in the home. These comments are included in section 4.5 of the report.

Two visiting general practitioners were also spoken with and commended the staff and the home very highly. Comments included;

"I have been a GP for 25 years and have been in a lot of nursing homes and I can say that Copperfield's is the best."

"In one word I would describe the home as excellent."

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations:	0

4.5 Is care compassionate?

Throughout the inspection there was a calm atmosphere in the home and staff were observed quietly attending to the patients' needs. Patients were sitting in the lounges or in their bedrooms as was their personal preference. The bedrooms as previously discussed had all been re-decorated and patients had been involved in choosing colour schemes and soft furnishings. Patients advised that they enjoyed this and that they appreciated being involved in these decisions. The home personified a very homely environment and comments made by patients and their representatives demonstrated that this was one of the many reasons for choosing to live in Copperfields.

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Patients appeared well dressed and there was evidence of staff's attention to detail regarding personal care, for example, ladies clothing were accessorised with co-ordinating neck scarfs and jewellery. A number of ladies had their hair set in rollers and advised that the staff had done this for them as part of their care and that the registered manager also took time to set their hair and they didn't have to wait on a hairdresser.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home. This was further evidenced at the time of a patient's death when the home held a service in respect of the deceased.

A discussion with a relative who had recently experienced the loss of their loved one who had been cared for in Copperfield's, commended the management and staff for the care and compassion shown to their loved one and the wider family circle. They advised that the registered manager considered all aspects of care to include; the physical, emotional and spiritual needs of the patient and also considered the needs of the family in a manner that demonstrated "true kindness and compassion" at what was a very difficult time. They advised that the family never had to ask, that the registered manager always anticipated their needs. The relative advised that they truly believed that these actions and gestures supported them and has helped them in the grieving process. The relative described how the home had gone that "extra mile" and how staff had supported them "over and above the call of duty" and that staff would bring a tray of tea and refreshments for the wider family circle when they visited to say their final goodbyes. The home also facilitated the wake and assisted the family in making the final arrangements. The relative advised that the registered person visited their loved one daily and always gained assurances that the patient and the family were being well looked after. The family advised that the registered manager was present at the time of death and

this was one of the personal wishes of the patient. This account highlighted the excellent practice in the domain of compassionate care.

Eight patients were spoken with individually during the inspection process and all commented very positively regarding the care, food and services provided to them. One patient said "very nice, a real hotel, the food and staff are excellent, they are kind and respectful and you couldn't ask for better".

All patients spoken with confirmed that both the registered manager and registered person were available to them on a daily basis. One patient said, "Henry the boss is very good and runs a good home".

As part of the consultation process the inspector asked the home to distribute questionnaires. Ten questionnaires were provided for staff and patient representatives and five for patients. At the time of writing this report five patient and five representative's questionnaires, and five staff questionnaires have been returned. All responses received were positive. All five questionnaires returned by patients indicated their satisfaction across all four domains.

Discussion with the registered person and manager confirmed that the views of patients, their representatives and staff on the running of the home were sought on a daily basis. On an annual basis, questionnaires were distributed and views and comments recorded were analysed and shared with staff, patients and representatives. A copy of the report was displayed in the main foyer of the home.

Areas for improvement

No areas for improvement were identified during the inspection.

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 the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff spoken with were able to describe their roles and responsibilities. In discussion patients were very aware of the roles of staff in the home and knew the registered manager and registered person well and advised that they had contact with them on a daily basis.

Staff were able to identify the person in charge of the home in the absence of the registered manager and the duty rota clearly recorded this information.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.
Patients and representatives spoken with confirmed that they were aware of the home's complaints procedure, a copy of which was displayed within each bedroom and others areas

within the home. Patients/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately.

Staff were knowledgeable of the complaints process and adult safeguarding process commensurate with their role and responsibilities.

A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately. Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events, complaints and/ or potential adult safeguarding concerns were investigated and reported to RQIA or other relevant bodies appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents. A review of the record of audits evidenced that these were not completed in a consistent manner and the registered manager agreed that a more systematic approach should be implemented. A recommendation has been made.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner. These included for example; drug and equipment alerts. There was evidence that the registered manager had reviewed the alerts, identified if the alert was applicable and if so the alert was shared with relevant staff.

Discussion with the registered person and registered manager and review of records evidenced that monthly monitoring reports in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland), 2005 were completed in detail, even though the registered person was available in the home on a daily basis. This is commended. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, and staff and Trust representatives.

Areas for improvement

A recommendation has been made that a more systematic approach should be implemented to monitor and report on the quality of nursing and other services provided.

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 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 should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for review 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 provider 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 provider 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 **Stated:** First time **To be completed by:** 11 July 2016	A system should be developed to monitor the registration status of care staff with the Northern Ireland Social Care Council (NISCC). **Ref: Section 4.3**
	Response by registered person detailing the actions taken: A system has been developed to monitor the registration status of care staff with the NISCC.
Recommendation 2 **Ref**: Standard 35 Criteria 16 **Stated:** First time **To be completed by:** 11 July 2016	The registered person should implement a more systematic approach to monitor and report on the quality of nursing and other services provided. **Ref: Section 4.6**
	Response by registered person detailing the actions taken: The registered manager has completed a wide range of audits and these will be undertaken more consistently to monitor the quality of care and services provided.

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

The Regulation and Quality Improvement Authority

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