Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

The Mount Camphill Community

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Tel: 01892782025

Date of Inspection: 10 October 2013

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We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Meeting nutritional needs	✓ Met this standard
Management of medicines	✓ Met this standard
Staffing	✓ Met this standard

Details about this location

Registered Provider	The Mount Camphill Community Limited
Overview of the service	The Mount Camphill Community is a college, based on the Steiner ethos, which provides accommodation and support for children and young adults with learning disabilities.
Type of service	Specialist college service
Regulated activity	Accommodation and nursing or personal care in the further education sector

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 10 October 2013, observed how people were being cared for and talked with people who use the service. We talked with staff.

What people told us and what we found

We spoke with two people who were studying at Mount Camphill Community. They told us "we are all friends here and I can choose what I want to do" and "I have a choice about what I do every day." People told us that staff were supportive and helpful. We observed kind interaction between staff and people and that people were included in everyday activities. We saw that Mount Camphill had systems in place to gain consent and we observed staff requesting consent and consulting with people.

We inspected records and concluded that record keeping was exemplary and well planned. Information was updated as required and intervention from outside agencies was timely.

We saw that people were actively involved in planning all activities within Mount Camphill, including meal preparation and the planning of healthy diets.

We saw that medication was stored correctly and that procedures were in place which managed medications in a safe way. From speaking with staff we could be sure that the management of medication was taken seriously, whilst still seeking to empower people.

We saw that staffing levels were appropriate with trained staff who were regularly supervised and monitored. We spoke with staff who confirmed that the training they received was timely and appropriate to the tasks required of them.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone

number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

We spoke with people who told us that their care was fully discussed with them, in detail, and their agreement was sought both verbally and in writing about the input they would like from staff. Part of this discussion related to the studies which people were undertaking whilst at Mount Camphill as care and education were intertwined and took into account skills required for independent living. People told us that their relatives had also taken part in the planning of their care.

We inspected three sets of care records; we found signed consent on care records which showed that people had given their consent to care and support being received. We saw that people had been consulted in designing an individual plan for their needs and were included in meetings. Staff used both non-verbal and verbal clues which helped to understand if a person was happy with the choices made; discussions were facilitated either via conversations or with the use of pictures and widgets. This meant that people were given as much information as possible to discuss their care needs, make choices and consent to support being provided. On one person's records it noted that the person had given consent by nodding and using eye contact; we felt sure that people who were non-verbal were given every opportunity to consent.

We read care plans and saw that these were updated every six months or more regularly if the need required. On two sets of notes we saw that discussions had taken place with people and they had agreed verbally, and then signed the notes to represent their consent. This meant that people who had verbal skills were able to consent to their care and support.

We saw that risk assessments and care support plans were person-focused and individual, suggesting that these had been drawn up with the person they related to. People confirmed to us that they had support offered to them and could make a decision as to whether they wished to have intervention from staff, for example with meal preparation. They also confirmed that they did take part in the planning of their support

plans. This meant that we were assured that people had sufficient knowledge and had been consulted and included in the planning of their care.

Issues related to people's capacity had been considered in line with the Mental Capacity Act and built into the establishment's policies, for example within the safeguarding procedure. This meant there were clear procedures which were followed and reviewed relating to consent and capacity.

Staff told us that capacity issues were considered when a person was choosing the support that they received and which courses they would major in. Support and information was given in an appropriate form to aid people to make informed choices. Where capacity needed to be established, outside professionals and relatives were involved.

We discussed with staff how they gained consent when they provided care. They told us that if a person declined care or support then this was discussed more fully with the person, but ultimately their decision was respected. If a person declined medical intervention, staff told us that this was reported to the appropriate senior support worker so that risks could be discussed with that person in detail. When speaking with people, they confirmed they had choice and did consent to care. One staff member told us "this has not happened since I've been working here as we work closely with people to find out exactly what they want". We observed good partnership working and staff checking with people that they wanted to support, which meant the staff were respectful in gaining consent.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We viewed three sets of care notes. We found that each person's records had an assessment completed prior to moving into the home, which was detailed and outlined their needs with regards to health, general well-being, and care needs. These assessments had been completed with information from the person themselves and their relatives. We were told by staff that people were invited for a trial visit from a Sunday to a Tuesday before making a decision about moving to Mount Camphill. They were also provided with information about the service and what to expect. This meant that people were able to make an informed decision about moving to Mount Camphill.

On inspecting care records we saw that each person had an individual assessment and support plan. These were person centred and written clearly with a person's needs and wishes recorded. Information about a person's preferences were recorded. We saw that care plans were regularly reviewed and there was a clear update on what people had achieved when working towards becoming more independent. We saw that support plans were extremely detailed with precise information which was broken down into individual sections, making it easy for staff to find information. Staff reported they were encouraged to feedback information to the House Coordinator (senior support worker) so this could be fed into the planning of care and support. We found that records were meticulously completed and the coordinators took responsibility for the updating of records. We spoke with people who told us that they had been asked what support they needed and were able to retain independence as they wished, and as was safe to do so.

We saw risk assessments on file which identified and described a specific risk and how to manage it. We saw that planning the management of risk included the views of the person and what positive interventions could be put in place to be least restrictive whilst also protecting that person and those around them. Risk planning covered a range of issues including unpredictable health conditions and managing heightened emotions. We concluded that the quality of risk assessing was thorough, appropriate and of a good standard. This meant that people could be sure that their care was planned and risks were correctly assessed.

Regular logs were completed to detail how a person was each week. Where there was a

need to record information more regularly, it was done so. The information recorded was detailed and included how a person's health was as well as mental well-being and any other relevant issues. On speaking with staff they were able to outline signs of concerns which would indicate a person was unwell, or experiencing emotional distress. This meant that information was gathered which could plot a deterioration in a person's well-being. Intervention from outside organisations was requested on a timely basis and followed up as necessary. We concluded that systems were in place to monitor a person's well-being and take appropriate steps and people could be confident that staff would respond quickly when a person required it.

We saw good recording of incidents which detailed what had happened and who or what was involved. We saw that these incident logs were then used to inform future planning and ways of managing the incident should it recur. This meant that situations had been analysed and people could be reassured that lessons were learned from incidents.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

Staff told us that meals were prepared alongside the people living at Mount Camphill; breakfast and supper preparation was led by people as part of their lifeskills learning. The main cooked meal, which was eaten at lunch-time, was prepared alongside staff with all units having a cook employed. People were encouraged to help plan the menu for the whole house and also to decide which dishes they would like to learn to prepare. People would cook each week for other people in the house. This meant that people were actively involved in preparing meals and were learning and expanding on these skills.

Staff told us ways in which they worked with people to help them understand what a balanced diet consisted of and how to shop, plan and prepare for a meal. This was done through talking and showing pictures. People would go to local shops and have choice about the foods they bought; in one unit people were learning to shop on line for groceries. This meant that people were assisted in different ways to become more independent with planning their meals.

We observed a mealtime; people were able to serve themselves, taking more food as they wished. The food was hot with vegetables, proteins and carbohydrates which indicated that nutritious food was available and in sufficient quantities.

Staff told us that they had in the past catered for individual diets such as diabetic and gluten free. We felt confident that people with specialised diets could be supported and catered for.

We observed the 'tuck shop' which was staffed by people living at Mount Camphill and provided snacks; this was open once a week and enabled people to make decisions and buy items within their budget.

Within the Mount Camphill grounds there was a bakery which supported everyone with freshly baked bread and biscuits. Mount Camphill was self-sufficient with goods made within the bakery. The bakery was worked in by people as part of their studies.

During house meetings, people could make decisions about what food they would like over the forthcoming period. If a person did not like the food being prepared, they were encouraged to try it but could have an alternate meal if required. Snacks and drinks were

available during the day and the set up within each home on site was observed to be relaxed. We saw that people entered the kitchen to prepare and serve food and set out the dinner table and that people understood their role. This meant there had been planning and a regular routine put in place to support people at meal times.

Kitchen and dining areas were clean and clear, with people taking part in the daily upkeep of these areas. This formed part of the lifeskills people were learning.

Weight was recorded monthly or more often by house coordinators where there was a concern about a person's weight. Staff told us of one situation where a learning disability nurse was involved to work with a person around their dietary needs. This meant that in more difficult situations, the home acted appropriately in securing support from other professionals to draw up guidelines.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

We saw that Mount Camphill had senior support workers ('House Coordinators' and 'Co-workers') on each shift who administered medication. Staff had been trained in medication awareness and administering, where appropriate. Staff told us about the training they received. Mount Camphill had a clear medication policy which was readily available.

We inspected the medication cabinet in one unit; the medication cabinet was kept locked with the key held within a key safe. The number for the key safe was only known by trained staff. All people living at Mount Camphill required support with medication, though people were encouraged to understand their medication and what it was needed for where a person had the ability to understand this. The medication record for each person was completed each time medication was administered; we viewed these logs and were satisfied they were completed to a high standard and were up to date which meant that the staff worked within the guidelines of the policy.

Each person's medication was held in the original packaging or in pharmacy made-up blister packs. The cupboard was well organised and free from clutter.

We saw that each person had an individual medication record. These medication records had the person's name, allergies, a list of medications used currently and a list of medications previously used. This meant that clear records were being kept. Where homely medications were in use, these were recorded on a separate list. Information leaflets about medication were kept alongside the records which meant that staff had access to information which could be shared, as appropriate, with people. Relatives were consulted in the use of medication.

We spoke with trained staff who told us that there was a regular audit, twice per term, of all medication to ensure that enough was held in the home and that the medication was in date and undamaged.

There was one controlled drug being used by one person living at Mount Camphill. This was kept in a safe secured to a wall. The key was held by the trained person on duty. We saw the controlled drug log was clearly completed and part of the medication policy

referred to the administration of controlled drugs.

Staff told us of having close links with a local pharmacy with whom they had had discussions about medication and storage facilities. An audit was completed annually by a pharmacy representative which meant that Mount Camphill were taking steps to ensure that the administration of medication was within national guidelines and that people using the service were protected by these actions.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

Mount Camphill was staffed by a combination of voluntary workers and paid staff. We spoke to staff who described that they had dedicated time set aside as time off from their duties, most staff/volunteers lived within the community. Each unit had a different amount of staff which was determined by the level of need of the people living in that unit. Where needs changed, staffing levels were altered to reflect that change. Weekly meetings were held between senior staff to look at the staff ratios.

We saw a detailed training matrix which showed mandatory training such as fire awareness and safeguarding had been completed. We inspected early within the first term of the academic year and found that training was planned for newer members of staff. Induction programmes were detailed and in line with National Vocational Qualifications. All staff with care related duties were working towards qualifications in care.

Staff told us that they were a close staff team who were able to provide cover for people should the need arise through sickness or other unexpected absences. Staff told us that it was rare for staff to leave within the time of their contract (which were renewed each academic year) and that staff retention was good. One staff member told us "I really love it. I stayed a second year because it's an amazing place to work."

Staff told us they felt supported by the management structure; "I speak to my supervisor if I have any difficulties and my co-workers", "There's not always an easy answer but we work together". We observed excellent staff discussions and respectful interaction between staff. We spoke with some of the management team who had a clear understanding of the needs of people and the staff. We concluded that staff felt well supported and valued in their work and the management structure was supportive.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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