Apple Blossom Lodge
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Unannounced Care Inspection
of
Apple Blossom Lodge

2 June 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 2 June 2015 from 09 50 to 16 00 hours.

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

Overall 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.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of 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 9 February 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	1	5

The details of the Quality Improvement Plan (QIP) within this report were discussed with Mark Jackson, clinical lead and nurse in charge of the home, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Larchwood Care Homes Ltd Ciaran Henry Sheehan	**Registered Manager:** Heather Maxwell
Person in Charge of the Home at the Time of Inspection: Mark Jackson, clinical lead	**Date Manager Registered:** 29 January 2015
Categories of Care: NH-DE, NH-MP, NH-MP(E)	**Number of Registered Places:** 40
Number of Patients Accommodated on Day of Inspection: 28	**Weekly Tariff at Time of Inspection:** £830

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 nurse in charge
- discussion with staff
- discussion with patients
- discussion with a relative
- 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
- application for variation to the home's registration submitted to RQIA on 23 May 2014
- written and verbal communication received since the previous care inspection
- the previous care inspection report

During the inspection, the inspector met with four patients individually and with the majority generally, one patient's relative, two registered nurses and five care.

The following records were examined during the inspection:

- care records of five patients
- policies and procedures
- record of complaints and compliments

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 9 February 2105. The completed QIP was returned and approved by the care inspector.

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 5.6 **Stated:** First time	The registered manager should ensure that all prescribed nursing care is delivered and records maintained to evidence care delivery.	**Met**
	Action taken as confirmed during the inspection: Review of a sample of care records evidenced that this recommendation has been met.	
Recommendation 2 **Ref**: Standard 5.7 **Stated:** First time	Care plan evaluations should include a meaningful statement of the patient's condition, including any changes, since the previous review.	**Met**
	Action taken as confirmed during the inspection: Review of a sample of care records evidenced that this recommendation has been met.	
Recommendation 3 **Ref**: Standard 3.1 **Stated:** First time	The Patient Guide should be updated to include the options available for transporting patients to hospital appointments.	**Met**
	Action taken as confirmed during the inspection: The Patient Guide available in the home was dated September 2014 and had not been updated to include the options available for transporting patients to hospital appointments. This recommendation is stated for a second time.	
Recommendation 4 **Ref**: Standard 32.8 **Stated:** First time	Patient weighing scales should be calibrated regularly and records maintained.	**Not reviewed**
	Action taken as confirmed during the inspection: This recommendation was not reviewed during this inspection and is carried forward for review at a future inspection.	

5.2 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy was available on communicating effectively which reflected current best practice, including regional guidelines on Breaking Bad News. The policy stated that "training in communication skill and the breaking of bad news must be provided to relevant members of staff." Training had not been provided on breaking bad news. However, discussion with the 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)

The 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. They explained that there were events which would trigger sensitive conversations with patients and/or their families, for example an increase in the number of admissions to hospital, and/or reoccurring symptom with a poor prognosis. They emphasised the importance of building caring relationships with patients and their representatives and the importance of regular, ongoing communication regarding the patient's condition.

Care staff considered the breaking of bad news to be, primarily, the responsibility of the registered nursing staff but felt confident that, should a patient 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 four patients individually and with the majority of patients generally evidenced that patients were content living in the home.

One patient's representative also 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.

Areas for Improvement

The registered person should review the working practices within the home to ensure that they are compliant with the internal policies reviewed.

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

5.3 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 end of life care and death and dying were available in the home. However the policy entitled "End of Life Care", issued 24 July 2014, did not reference 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.

The GAIN Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes, December 2013 were not available in the home.

A policy on the management of death and dying was available and the management of the deceased person's belongings and personal effects was included in the policy. Staff demonstrated good understanding of the importance of how patient's personal effects are managed following their death.

The policy on the death of a patient stated that patients preferred funeral arrangements should be included in their care plan. The policy also stated that staff should check the care plan to determine if there were any religious, ethnic or cultural considerations to be observed before handling the body. As discussed in the next section of this theme care records did not contain information on patients' individual needs and wishes regarding end of life care.

The policy entitled "Dealing with the cultural traditions and beliefs of residents" stated that at the time of admission to the home information would be obtained regarding the cultural and religious needs of patients and that this information should be recorded in the patients care plan. This information was not recorded in the care records reviewed. As discussed in section 5.2 the registered person should review the working practices within the home to ensure that they are compliant with internal policies.

Formal training in the management of death, dying and bereavement had not been provided. However registered nurses and care staff demonstrated experience and knowledge of the action to take in the event of a patient's death.

Discussion with the registered nurses confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services through the local health and social care trust. The provision of syringe drivers for symptom management was provided by the local health and social care trust. Procedures for timely access to any specialist equipment or drugs were in place and discussion with the registered nurses confirmed their knowledge of the procedure.

Registered nurses and care staff were knowledgeable in identifying when a patient's condition was deteriorating or nearing end of life and the recognition of pain and pain management.

Is Care Effective? (Quality of Management)

There was no section in the assessment and care planning documentation relating to the identification of religious/spiritual needs or end of life care. The five care records reviewed did not contain any information of patients' individual needs and wishes regarding end of life care.

The registered nurses explained that discussions and care planning regarding end of life care were generally triggered by a deterioration in the patient's physical condition. However they acknowledged that there was a need to create further opportunities to discuss this area in greater detail; in particular in the event of patients becoming suddenly unwell and with those patients who had no family contact.

Discussion with the two registered nurses and five 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 had been reported appropriately.

Is Care Compassionate? (Quality of Care)

Of the five care records reviewed, only one evidenced that the patient had been consulted in respect of their religious, cultural and spiritual preferences. The needs identified did not extend to end of life care. The religious, spiritual or cultural need of the other four patients had not been recorded. 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 to support patients' with their religious and spiritual needs within the home but this were not reflected in the care records.

Staff spoken with provided a number of examples of their experience of providing end of life care for patients. One care assistant explained how they had supported a patient with a terminal diagnosis. The patient did not wish to discuss their diagnosis. The care staff explained that, in the absence of close family, by asking general questions about his likes and dislikes, they were able to gain the necessary information to personalise his funeral. The staff member explained "it's about knowing your patients and then deciding how best to get the information." She demonstrated great compassion when discussing this.

Arrangements were in place in the home to facilitate family and friends to spend as much time as they wish with the patient. Staff discussed openly a number of recent deaths in the home 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 nurse in charge, six staff and a review of the compliments record, there was evidence that there were sound arrangements in the home to support relatives during this time. Compliments had been received by the home from relatives and friends of former patients.

One letter contained the following comment:

"It brought us great comfort to know that … was well cared for within the family of Apple Blossom, very especially the compassionate and professional care both … and all the family members received during his last days, brought us great peace and comfort."

A review of the complaints records evidenced that no concerns were raised in relation to the arrangements regarding the end of life care of patients in the home.

All of the staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death. From discussion with the nurse in charge and staff, it was evident that arrangements were in place to support staff following the death of a patient.

Areas for Improvement

It is recommended that the policy on end of life care is reviewed and updated to ensure that it is 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.

As previously stated the registered person should review the working practices within the home to ensure that they are compliant with internal policies reviewed.

It is recommended that end of life arrangements for patients are discussed and documented as appropriate, and include patients' wishes in relation to their religious, spiritual and cultural needs.

Number of Requirements:	**0**	**Number of Recommendations: *1 recommendation made is stated under Standard 19 above**	**3***

5.4 Additional Areas Examined

5.4.1 Consultation with patients, their representatives, staff and professional visitors

Patients

Discussion took place with four patients individually and with the majority of others in smaller groups. Comments from patients regarding the quality of care, food and in general the life in the home were positive. Patients stated that the recent provision of a bus for the home had improved their quality of life by proving opportunities for social outings.

One patient raised an issue regarding the management of his care. The concerns were shared with the nurse in charge who agreed to discuss the area further with the patient and give consideration to the request.

Another patient alleged that he had property stolen from his room at a time when he had lost his key and left his room unlocked. It was agreed that the allegation would be discussed with the management of the home. The nurse in charge was aware of the issue and of the action taken at the time the patient reported it, approximately ten days prior to the inspection. The home were unable to substantiate the allegation and had provided the patient with additional advice on security of his possessions. However the allegation was not recorded and there was no record of the action taken in response to the allegation. The patient's care manager had not been informed.

It is required that services are provided to meet the individual needs of the patient. Therefore all allegations of theft must be viewed as serious and records maintained of the details of the allegation, action taken and outcome of the investigation. All allegations of theft must be reported to the relevant authorities.

It was agreed that the nurse in charge would:

- Record the allegation and the follow up taken by the home
- inform the patients care manager
- submit a notification to RQIA detailing the incident, the action taken by the home and the outcome

The registered manager notified RQIA on 16 June 2015 that the agreed action had been completed.

Relatives

One patient's representatives confirmed that they were happy with the standard of care and communication with staff in the home.

Staff

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. Six were returned following the inspection visit. Staff indicated that they were satisfied or very satisfied that care was safe, effective and compassionate. One respondent indicated that they were unsatisfied that patients received timely support from members of the multidisciplinary team and unsatisfied with the supportive systems in place to inform patients and staff of a death. No additional comments were provided to quantify the opinions expressed.

Comments received in the questionnaires included:

"I have found in end of life care, all staff pull together throughout the process."
"…it was important to care for the family of the residents as well as for the residents themselves. Simple things like refreshments for family can help in a time of need."

"Apple Blossom Lodge has a good work environment. In my time there the care is excellent"

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mark Jackson, clinical lead and nurse on charge of the home, 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 the 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	
Requirements	
Requirement 1 **Ref**: Regulation12(1)(a) **Stated:** First time **To be Completed by:** 30 June 2015	The registered person must ensure that services are provided to meet the individual needs of the patient. All allegations of theft must be viewed as serious and records maintained of the details of the allegation, action taken and outcome of the investigation. All allegations of theft must be reported to the relevant authorities.
	Response by Registered Person(s) Detailing the Actions Taken: All allegations of theft are taken seriously and reported to the relevent authorities. The case referred to above has identified shortcomings in the recording of the detail of small jewellry items kept within a residents bedroom. This shortcoming has been corrected.
Recommendations	
Recommendation 1 **Ref**: Standard 3.1 **Stated:** Second time **To be Completed by:** 30 June 2015	The Patient Guide should be updated to include the options available for transporting patients to hospital appointments.
	Response by Registered Person(s) Detailing the Actions Taken: The Patient Guide has been updated and forwarded to the Inspector.
Recommendation 2 **Ref**: Standard 32.8 **Stated:** Second time **To be Completed by:** 30 June 2015	**Carried forward for review at a future inspection** Patient weighing scales should be calibrated regularly and records maintained.
	Response by Registered Person(s) Detailing the Actions Taken: Patient weighng scales are regularly calibrated by the Manager and these records are available within the Clinical room located in the first floor of the building. The regularity of this process has been increased to 2 weekly.
Recommendation 3 **Ref**: Standard 36.1 **Stated:** First time **To be Completed by:** 14 July 2015	It is recommended that the working practices within the home are reviewed to ensure that they are compliant with internal policies.
	Response by Registered Person(s) Detailing the Actions Taken: Training identified within the policies has been planned and staff will receive training on 'Breaking bad news' on 20.08.15

Recommendation 4 **Ref**: Standard 32 **Stated:** First time **To be Completed by:** 14 July 2015	It is recommended that the policy on end of life care is reviewed and updated to ensure that it is 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. **Response by Registered Person(s) Detailing the Actions Taken:** The policy on end of life care is currnelty under review and this will be completed by 31/07/15
Recommendation 5 **Ref**: Standard 32.1 **Stated:** First time **To be Completed by:** 14 July 2015	It is recommended that end of life arrangements for patients are discussed and documented as appropriate, and include patients' wishes in relation to their religious, spiritual and cultural needs. **Response by Registered Person(s) Detailing the Actions Taken:** End of life arrangements are now discussed as appropriate and documented within the care plan.

Registered Manager Completing QIP	Heather Maxwell	**Date Completed**	23/07/15
Registered Person Approving QIP	Ciaran Sheehan	**Date Approved**	23/07/15
RQIA Inspector Assessing Response	Sharon McKnight	**Date Approved**	3-11-15

Please ensure the QIP is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address*

I agree with the content of the report.			
Registered Manager	Heather MAxwell	**Date Completed**	23/07/15
Registered Person	Ciaran Sheehan	**Date Approved**	23/07/15
RQIA Inspector Assessing Response		**Date Approved**	

Please provide any additional comments or observations you may wish to make below:

Please complete in full and returned to RQIA nursing.team@rqia.org.uk *