Unannounced Care Inspection

Name of Establishment:	**Apple Blossom Lodge**
RQIA Number:	**1501**
Date of Inspection:	**7 November 2014**
Inspector's Name:	**Sharon McKnight**
Inspection ID:	**IN017204**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Apple Blossom Lodge
Address:	62 Drumilly Road Armagh BT61 8RH
Telephone Number:	(028) 3889 1202
Email Address:	heather.maxwell@larchwoodni.com
Registered Organisation/ Registered Provider:	Larchwood Homes (NI Ltd) Ciaran Sheehan
Registered Manager:	Ms Heather Maxwell (Registration with RQIA is being processed)
Person in Charge of the Home at the Time of Inspection:	Heather Maxwell
Categories of Care:	NH-DE, NH-MP, NH-MP(E)
Number of Registered Places:	40
Number of Patients Accommodated on Day of Inspection:	26
Scale of Charges (per week):	£537.00 - £577.00
Date and Type of Previous Inspection:	27 January 2014 Announced primary inspection
Date and Time of Inspection:	7 November 2014 09 50 – 15 50 hours
Name of Inspector:	Sharon McKnight

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect nursing homes. A minimum of two inspections per year are required.

This is a report of an inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection are being met.

3.0 Purpose of the Inspection

The purpose of this inspection was to consider whether the service provided to patients was in accordance with their assessed needs and preferences and was in compliance with legislative requirements, minimum standards and other good practice indicators. This was achieved through a process of analysis and evaluation of available evidence.

The Regulation and Quality Improvement Authority aims to use inspection to support providers in improving the quality of services, rather than only seeking compliance with regulations and standards. For this reason, annual inspection involves in-depth examination of a limited number of aspects of service provision, rather than a less detailed inspection of all aspects of the service.

The aims of the inspection were to examine the policies, practices and monitoring arrangements for the provision of nursing homes, and to determine the Provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008)
- other published standards which guide best practice may also be referenced during the Inspection process.

4.0 Methods/Process

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

- discussion with the home manager
- discussion with staff
- discussion with patients individually and with others in groups
- review of a sample of staff training records
- review of a sample of care records
- observation during a tour of the premises
- evaluation and feedback.

5.0 Consultation Process

During the course of the inspection, the inspector spoke with:

Patients/Residents	All of the patients either individually or in groups.
Staff	**7**
Relatives	**0**
Visiting Professionals	**0**

Questionnaires were provided by the inspector, during the inspection, to patients and staff to seek their views regarding the quality of the service.

Issued To	Number Issued	Number Returned
Patients/Residents	**6**	**4**
Relatives/Representatives	**0**	**0**
Staff	**12**	**7**

6.0 Inspection Focus

Prior to the inspection, the responsible person/registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by the responsible person/registered manager in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

However, due to workload pressures and contingency measures within the Regulation Directorate, the themes/standards within the self-assessment were not inspected on this occasion

This inspection sought to establish the level of compliance being achieved with respect to the following DHSSPS Nursing Homes Minimum Standard and to assess progress with the issues raised during and since the previous inspection:

Standard 19 - Continence Management

Patients receive individual continence management and support.

The inspector has rated the home's Compliance Level against each criterion and also against each standard.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance Statements		
Compliance Statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report.
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report.
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report.
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report.
4 - Substantially compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report.
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

7.0 Profile of Service

Apple Blossom Lodge was formally registered with RQIA as The Retreat. However, in July 2014 following a change of ownership the home name was changed and registered as Apple Blossom Lodge.

Apple Blossom Lodge is owned by Larchwood Care Homes (Ltd). The responsible individual is Mr Ciaran Sheehan. The home manager is Ms Heather Maxwell. An application for registered manager has been submitted to RQIA and is currently being processed.

The home is located approximately two miles from the village of Loughgall. It is a two storey house with accommodation provided over two floors. Access to the first floor is via a passenger lift or stairs. A number of lounges and dining rooms are located throughout the home. Bedroom accommodation is provided in single rooms. A number of toilets, bathrooms and shower rooms are available in the home ensuring that bathing/showering facilities are available to meet the needs of patients. There is a designated smoking room in the ground floor with access to an enclosed courtyard. Catering and laundry services are located on the ground floor.

There are well maintained gardens with car parking provided to the front and rear of the premises.

The home provides accommodation for a maximum of 40 gentlemen and is registered to provide care under the following categories of care:

Nursing care (NH)

MP - mental disorder excluding learning disability or dementia

MP (E) - mental disorder excluding learning disability or dementia - over 65 years

DE - dementia.

8.0 Executive Summary

This unannounced inspection of Apple Blossom Lodge was undertaken by inspector Sharon McKnight on 7 November 2014 between 09 50 and 15 50 hours. The inspection was facilitated by Ms Heather Maxwell, home manager, Verbal feedback was also provided to Ms Maxwell at the conclusion of the inspection.

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous inspection of 27 January 2014.

As a result of the previous inspection six requirements and six recommendations were issued. These were reviewed during this inspection and the inspector evidenced that all of the requirements and recommendations have been fully complied with. Details can be viewed in the section immediately following this summary.

The inspector reviewed assessments and care plans in regard to the management of continence in the home. Review of patient's care records evidenced that patients and/or their representatives were informed of changes to patient needs or condition.

Nursing staff spoken with on the day of the inspection were knowledgeable regarding the management of urinary catheters and the frequency with which the catheters require to be changed. Currently there were a number of registered nurses who are trained in male catheterisation. The home manager informed the inspector that further training and competency assessments were being arranged for those registered nurses not trained.

From a review of the available evidence, discussion with relevant staff and observation, the inspector can confirm that the level of compliance with the standard inspected is substantially compliant.

Additional Areas Examined

Care practices
care records
human rights and deprivation of liberty safeguards (DOLS)
complaints
patient finance questionnaire
NMC declaration
patients comments
staff comments
environment.

Details regarding the inspection findings for these areas are available in the main body of the report.

Conclusion

The inspector can confirm that at the time of this inspection, the delivery of care to patients was evidenced to be of a good standard and patients were observed to be treated by staff with dignity and respect. Good relationships were evident between staff and patients. Patients were well groomed, appropriately dressed and appeared comfortable in their surroundings. Those patients who were unable to verbally express their views were also observed to be well groomed, appropriately dressed in clean matching attire and were relaxed and comfortable in their surroundings.

As a result of this inspection one requirement and two recommendations were made with regard to care records.

The inspector would like to thank the patients, home manager, registered nurses and staff for their assistance and co-operation throughout the inspection process.

The inspector would also like to thank the patients and staff who completed questionnaires.

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	Regulation 18(2)(j)	Appropriate action must be taken to eliminate odours.	**There were no malodours identified during this inspection. This requirement is assessed as compliant.**	**Compliant.**
2	Regulation 29(4)(c)	It is required that the person carrying out the monthly, unannounced visit prepares a report on the conduct of the home. This report must be issued in a timely manner.	**Review of the reports of the regulation 29 visits evidenced that this requirement has been complied with.**	**Compliant.**
3	Regulation 17(2)	It is required that copy of the annual report is submitted to RQIA by 30 April 2014.	**A copy of the annual quality report was received by RQIA on 28 July 2014. This requirement is assessed as compliant.**	**Compliant.**
4	Regulation 14(4)	It is required that the procedures for protecting vulnerable adults are included in the induction programme for staff.	**Review of two completed staff induction records evidenced that procedures for the safeguarding of vulnerable adults was included.**	**Compliant**

5	Regulation 16(1)	Care plans must be further developed to clearly guide staff in the management of patients' behaviour if they become physically aggressive. Any interventions prescribed must be discussed and agreed with the relevant healthcare professionals, the patient and family, were appropriate. Prescribed interventions must be reflective of best practice guidance.	**Review of care records for three patients evidenced that this requirement has been complied with.**	**Compliant**

6	Regulation 27(2)(b)	It is required that the premises are kept in a good state of repair. Therefore the necessary work to the identified shower room must be completed as a matter of urgency. The registered manager must notify RQIA of the progress of the repair work as agreed.	**The required work in the identified shower room had been completed and was fully operational on the day of inspection.**	**Compliant**

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	5.1	It is recommended that an agreed plan of care to meet the patient's immediate care needs are created on the day of admission, with further care plans being created as the patient settles into the home.	**Review of care records evidenced that this recommendation has been complied with.**	**Compliant.**
2	28.6	It is recommended that a record of the content of training and the qualifications of the trainer are kept in the home.	**Training records reviewed contained the content of the training and the qualifications of the trainer.**	**Compliant**
3	5.3	It is recommended that the care plans are updated to reflect recommendations made by visiting healthcare professionals.	**Review of care records evidenced that this recommendation has been complied with.**	**Compliant.**
4	5.3	It is recommended that care plans include the frequency with which dressings require to be renewed.	**Review of care records evidenced that this recommendation has been complied with.**	**Compliant**

5	5.3	It is recommended that all patients have a baseline pain assessment completed and an on-going pain assessment where indicated.	**Review of care records evidenced that this recommendation has been complied with.**	**Compliant**
6	11.7	It is recommended that formal training in skin care and wound management is arranged as part of the registered nurses professional development.	**Review of training records evidenced that the training recommended took place in June and October 2014 and that registered nurses and care staff attended.**	**Compliant.**

9.1 Follow up on any issues/concerns raised with RQIA since the previous inspection such as complaints or safeguarding investigations.

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home.

Since the previous inspection on 27 January 2014, RQIA have been notified, by the home manager, of ongoing investigations in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues.

Following discussion with the home manager RQIA were satisfied that SOVA issues were dealt with in the appropriate manner and in accordance with regional guidelines and legislative requirements.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of four patients' care records evidenced that bladder and bowel continence assessments were undertaken. The outcome of these assessments clearly identified the patients' needs. Not all identified needs had a care plan in place to direct the care required. For example; the type of continence products that patients' required was not incorporated into the patients' care plans on continence care and there was no reference to the Bristol Stool Chart and the patients' normal stool type. A recommendation has been made. Assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their GPs as appropriate. The management of urinary catheters was reviewed. The frequency with which catheters were required to be changed recorded in the care plan. Care records evidenced that catheters were changed regularly and in accordance with the recommended frequency. Review of patient's care records evidenced that patients and/or their representatives were informed of changes to patient need and/or condition and the action taken. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	Substantially compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
Policies and procedures were in place to guide staff regarding the promotion of bladder and bowel continence, catheter care and management of incontinence.	Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
This area was not assessed on this occasion.	Not assessed.
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
Nursing staff spoken with, on the day of the inspection, were knowledgeable regarding the management of urinary catheters and the frequency with which the catheters required to be changed. Currently there were a number of registered nurses who undertake male catheterisation. The home manager informed the inspector that further training and competency assessments were being arranged for those nurses not yet trained. There was length discussion with the home manager regarding the qualifications and competency of any person delivering training for invasive procedures.	Compliant.

Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**

11.0 Additional Areas Examined

11.1 Care Practices

The home manager informed the inspector that the philosophy of care was currently under review for those patients with enduring mental health needs. The review process was to ensure that a greater emphasis on enablement for patients was embedded into practice. Some changes had been implemented following review such as, a patient meeting was now held each morning, facilitated by the activity co-ordinator. Review of the record of outcome from these meetings evidenced that patents decided who would attend to the animals, what activities would take place that day and, if patients required anything from the local shop andwho was responsible for organising this. There was also an opportunity for patients to reflect on the previous day and discuss any concerns or issues. These daily meeting are good practice.

During the inspection staff were noted to treat the patients with dignity and respect. Good relationships were evident between patients and staff. Patients were well presented with their clothing suitable for the season. Staff were observed to respond to patients' requests promptly.

11.2 Care records

Care records contained care plans that were either individually hand written or typed and printed on a computer. The care plans which were typed and printed contained the name of the registered nurse who had created the care plan but did not contain the signature. It is required, in keeping with professional standards that care records are signed by the registered nurse completing them.

The inspector reviewed the incident reports of challenging behaviour. Some reports included what, if any, triggers to the behaviour had been observed. However other reports only stated if a trigger had been identified. It is recommended that a full description of what the trigger was is recorded to inform staff and assist them to proactively minimising episodes of aggression.

11.3 Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS)

The inspector discussed deprivation of liberty with the home manager who was aware of the Human Rights Act 1998 and deprivation of liberty issues. The Department of Health guidance document "Deprivation of Liberty, A Guide for Hospitals and Care Homes" was available in the home. Nursing staff informed the inspector that they were currently working on deprivation of liberty care plans for each patient.

The inspector reviewed the management of restrictive practices within the home. Staff spoken with had a good awareness of what constituted restrictive practice and how to manage situations. Care records reviewed reflected that restrictive practice, for example the availability of cigarettes, was appropriately managed.

11.4 Complaints

A complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. The evidence provided in the returned questionnaire indicated that complaints were being pro-actively managed.

11.5 Patient Finance Questionnaire

Prior to the inspection a patient financial questionnaire was forwarded by RQIA to the home for completion. The evidence provided in the returned questionnaire indicated that patients' monies were being managed in accordance with legislation and best practice guidance.

11.6 NMC Declaration

Prior to the inspection the home manager was asked to complete a proforma to confirm that all nurses employed were registered with the Nursing and Midwifery Council of the United Kingdom (NMC).

The evidence provided in the returned proforma indicated that all registered nurses, including the home manager, were appropriately registered with the NMC and that the registration status of all nursing staff was checked at the time of expiry.

11.7 Patients Comments

During the inspection the inspector spoke with all of the patients individually or in small groups. Four patients also completed questionnaires.

Patients' comments/responses confirmed that patients were treated with dignity and respect, that staff were polite and respectful, that they could call for help if required, that their needs were met in a timely manner, that the food was good and plentiful and that they were happy living in the home.

There were no concerns raised by patients during the inspection.

11.8 Staff Comments

During the inspection the inspector spoke with seven staff. Staff spoken with commented positively in regard to the care delivery in the home, management and the support and training available. Staff were knowledgeable regarding individual patient need.

Seven staff completed questionnaires. Staff responses indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes.

One respondent indicated that they were dissatisfied with the time they had to listen and talk to patients. Staffing levels were discussed with the home manager and were in keeping with RQIA guidelines. No issues were raised by staff on the day of inspection.

Examples of staff comments were as follows;

"All staff strive to do their best to ensure our residents are treated with respect and dignity…"
"…to give them a feeling of contentment as if they were back in their own home…"
"…very satisfied with the care the patients are receiving…"
"…the animals have been good for staff and residents…"
"…things have changed for the better…"

11.9 Environment

The inspector undertook an inspection of the premises and viewed the majority of the patients' bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and all areas were maintained to a good standard of hygiene.

A programme of refurbishment was being completed within the home. At the time of this inspection the entrance hall had been redecorated with new flooring fitted, the ground floor lounge and dining room had been redecorated and new curtains and flooring fitted. There was also a rolling programme to refurbish the bedrooms throughout the home.

The laundry had been refitted and includes facilities for patients to do their own washing. This is in keeping with the enablement model within the homes' philosophy of care. Staff will provide supervision and assistance as required. A full range of laundry services is available for those patients who require them.

On the first floor a small bedroom and visitors' room have been combined to make a spacious lounge with a small dining area. The activity room has been fitted with a kitchenette which can be used for activities or as a training kitchen for patients who hope to move back to independent living.

An application for variation to registration was submitted to RQIA prior to the refurbishment work commencing.

The inspector concluded that the improvements made to the environment, to date have been finished to a high standard and enhance the quality of life for the patients accommodated.

The grounds of the home now provide accommodation to goats and chickens. Discussion with patients and observations made evidenced that the introduction of the animals has made a positive impact on patients.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Heather Maxwell, as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the Quality Improvement Plan.

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.

Enquiries relating to this report should be addressed to:

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The Regulation and Quality Improvement Authority
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5 Lanyon Place
Belfast
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Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
5.1 A validated assessment tool is used on each patients admission to draw up an agreed care plan to meet the patients immediate care needs.. Information received from the care management team, the patient and relatives informs this assessment. 5.2 A comprehensive, holistic assessment based on Roper Logan and Tierney ia completed within 11 days of admission. 8.1 Community Nutrition Screening Tool is (based on MUST) is carried out with patients on admission. 11.1 The Braden assessment tool is used to assess the risk of pressure ulcers, prior to admission where possible and on admission.	Compliant

Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
5.3 A named nurse has responsibility for planning and agreeing nursing interventions to meet identified assessed needs with individual patients and their representatives. Each patient also has two associate carers. The nursing care plans, in most instances, demonstrate the promotion of maximum independence and take into account advice and recommendations from relevent health proffessionals. This is an area we are working hard to improve. 11.2 Referral arrangements are in place to obtain advice and support from relevent health professionals 11.3 Where a pateint is at risk of developing pressure ulcers, a documented prevention and treatment programme is in place in most instances and agreed by relevant health professionals. This is an area we are working hard to improve. 8.3 Referral arrangements are in place for the dietician to assess individual patients nutritional requirements. The nutritional treatment plan is developed taking account from relevant professionals in most instances. This is an area we are working hard to improve.	Substantially compliant

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.4 Whist re-assessment is an ongoing process which is evidenced in nursing notes, the nursing care plans require improvement and this is an area we are currently focused on.	Moving towards complian

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.5 All nursing interventions, activities and procedures are supported by research evidence and guidelines. 11.4 The Braden sclae is used to inform an appropriate treatment plan which is then implemented. 8.4 There are up to date nutritional guidelines which are used by staff on a daily basis. (published 2014)	Compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.6 Contemporaneous nursing records are kept of all nursing interventions and procedures. The extent to which these notes are outcome focused is undergoing review and is an area for improvement. 12.11 There is a detailed record of meals which would enable judgement of whether the diet for each patient is satisfactory. 12.12 Where a care plan requires, or when a patient is unable to or chooses not to eat, a record of dietry intake is maintained. Where a patient is eating excessively a record is maintained. Referrals are made to the necessary professionals however records require improvement in their accuracy and promptness. This is an area we are improving.	Moving towards complian

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Each patients care is monitored and recorded daily. Care plans are reviewed monthly. We are improving our focus on outcomes based practice, and the care planning process which will reflect this.	Moving towards complian

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.8 Patients are encouraged and faciltitated to participate in all aspects of their care including contributing to and attending multi disciplinary reviews arranged by local HSC Trusts. 5.9 The results of review meetings are recorded and care plans revised to reflect the outcome of the review. Patients and their representatives are involved in drawing up the plan to meet the agreed goals.	Substantially compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
12.1 Menus evidence that patients are provided with a varied an nutritious diet which meet their individual and recorded dietry needs and preferences. Full account is taken of relevant guidance documents however guidance provided by dietitions is not always evidenced as being followed. This is an area we are urgently improving. 12.3 Menus evidence choice. Alternative meals are provided where niether option is suitable.	Substantially compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
8.6 All nurses and carers receive training in feeding techniques for patients who have swallowing difficulties and in ensuring instructions drawn up by the speech and language therapist are adhered to. 12.5 Meals are provided at conventional times, hot and cold snacks are available as is fresh drinking water at all times. 12.10 Staff are aware of matters concerning patients eating and drinking as detailed in each patients care plan and adequate numbers of staff are present when meals are served. 11.7 Nurses are trained in wound management and this is updated annually.	Substantially compliant

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	COMPLIANCE LEVEL
	Substantially compliant

Appendix 2

Explanation of coding categories as referenced in the Quality of Interaction Schedule (QUIS)

Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.	**Basic care: (BC) – basic physical care e.g. bathing or use if toilet etc. with task carried out adequately but without the elements of social psychological support as above. It is the conversation necessary to get the task done.**
• Staff actively engage with people e.g. what sort of night did you have, how do you feel this morning etc. (even if the person is unable to respond verbally) • Checking with people to see how they are and if they need anything • Encouragement and comfort during care tasks (moving and handling, walking, bathing etc.) that is more than necessary to carry out a task • Offering choice and actively seeking engagement and participation with patients • Explanations and offering information are tailored to the individual, the language used easy to understand ,and non-verbal used were appropriate • Smiling, laughing together, personal touch and empathy • Offering more food/ asking if finished, going the extra mile • Taking an interest in the older patient as a person, rather than just another admission • Staff treat people with respect addressing older patients and visitors respectfully, providing timely assistance and giving an explanation if unable to do something right away • Staff respect older people's privacy and dignity by speaking quietly with older people about private matters and by not talking about an individual's care in front of others	Examples include: Brief verbal explanations and encouragement, but only that the necessary to carry out the task No general conversation

Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.	**Negative (NS) – communication which is disregarding of the residents' dignity and respect.**
Examples include: • Putting plate down without verbal or non-verbal contact • Undirected greeting or comments to the room in general • Makes someone feel ill at ease and uncomfortable • Lacks caring or empathy but not necessarily overtly rude • Completion of care tasks such as checking readings, filling in charts without any verbal or non-verbal contact • Telling someone what is going to happen without offering choice or the opportunity to ask questions • Not showing interest in what the patient or visitor is saying	**Examples include:** • Ignoring, undermining, use of childlike language, talking over an older person during conversations • Being told to wait for attention without explanation or comfort • Told to do something without discussion, explanation or help offered • Being told can't have something without good reason/ explanation • Treating an older person in a childlike or disapproving way • Not allowing an older person to use their abilities or make choices (even if said with 'kindness') • Seeking choice but then ignoring or over ruling it • Being angry with or scolding older patients • Being rude and unfriendly • Bedside hand over not including the patient

References

QUIS originally developed by Dean, Proudfoot and Lindesay (1993). The quality of interactions schedule (QUIS): development, reliability and use in the evaluation of two domus units. *International Journal of Geriatric Psychiatry* Vol *pp 819-826.

QUIS tool guidance adapted from Everybody Matters: Sustaining Dignity in Care. London City University.

Quality Improvement Plan

Secondary Unannounced Care Inspection

Apple Blossom Lodge

7 November 2014

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with home manager, Ms Heather Maxwell either during or after the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers / managers should note that failure to comply with regulations may lead to further enforcement and/ or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider / manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan 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.

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 (NI) 2005

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	25(b)	Care records must be signed by the registered nurse completing them. **Ref section 11, 11.2**	One	All care records are now signed by the registered nurse completing them.	From the date of inspection.

Recommendations

These recommendations are based on The Nursing Homes Minimum Standards (2008), research or recognised sources. They promote current good practice and if adopted by the Registered Person may enhance service, quality and delivery.

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	19.1	Care plans should be in place to direct how the patients' needs are to be met. The following should be included in patients' care plans: • the type of continence products that patients' require • reference to the Bristol Stool Chart and the patients' normal stool type. **Ref section 10, criterion 19.1**	One	The following is now included in the patients care plans. The type of continence products that each patient requires A Bristol stool chart and the patients nowmal stool type is noted as baseline	By the end of December 2014.
2	10.1	A full description of any triggers identified prior to an episode of challenging behaviour should be recorded to inform and assist staff to proactively minimise episodes of challenging behaviour. **Ref section 11, 11.2**	One	STAR charts are now included in each patients care file detailing triggers to any behaviours noted.	From the date of inspection.

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person:

NAME OF REGISTERED MANAGER COMPLETING QIP	Heather MAxwell
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Ciaran Sheehan

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	X	Sharon McKnight	20-02-15
Further information requested from provider			