Unannounced Secondary Care Inspection

Name of Establishment:	**Apple Blossom Lodge**
RQIA Number:	**1501**
Date of Inspection:	**9 February 2015**
Inspectors' Name:	**Sharon McKnight & Lorraine Wilson**
Inspection ID:	**21165**

The Regulation And Quality Improvement Authority
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

1.0 General Information

Name of Home:	Apple Blossom Lodge
Address:	62 Drumilly Road Armagh BT61 8RH
Telephone Number:	02838891202
Email Address:	heather.maxwell@larchwoodni.com
Registered Organisation/ Registered Provider:	Larchwood Care Homes (NI) Ltd
Registered Manager:	Heather Maxwell
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:	27
Date and Type of Previous Inspection:	7 November 2014 Secondary Unannounced Care Inspection
Date and Time of Inspection:	9 February 2015 10 05 – 16 40
Names of Inspectors:	Sharon McKnight and Lorraine Wilson

1.0 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.

1.1 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

1.2 Methods/Process

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

- Discussion with the registered manager
- Discussion with staff
- Discussion with patients
- Review of a sample of policies and procedures
- Review of a sample of staff training records
- Review of a sample of care plans
- Review of the complaints record
- Evaluation and feedback
- Observation during a tour of the premises.

1.3 Inspection Focus

This inspection was carried out in response to correspondence received by RQIA on 23 January 2015 expressing concerns regarding standards of care. For further information refer to section 4.1 of the report.

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.

2.0 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 registered manager is Ms Heather Maxwell.

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.

3.0 Summary

This unannounced inspection of Apple Blossom Lodge was undertaken by inspectors Sharon McKnight and Lorraine Wilson on 9 February 2015 between 10 05 and 16 40 hours. The inspection was facilitated by Ms Heather Maxwell, registered manager and Ms Jolene Craig, clinical lead. Verbal feedback was also provided to Ms Maxwell at the conclusion of the inspection.

Prior to the inspection RQIA received correspondence from a complainant who raised a number of concerns regarding care delivery. As part of the inspection process the registered manager, staff and patients were consulted and a number of records examined. As a result of the previous inspection conducted on 7 November 2014 one requirement and two recommendations were issued. These were reviewed during this inspection and the inspectors evidenced that they have been fully complied with.

Inspection Findings

The management of nutrition and monitoring of patients' weight evidenced that appropriate action was taken in response to patients losing weight or eating excessively. There was evidence of patient referral to healthcare professionals within the local health and social care Trust. The servicing and calibration of the weighing scales was discussed with the registered manager who confirmed that the scales were included in the service agreement with a medical equipment provider. It is recommended that patient weighing scales are calibrated in accordance with manufacturer's instructions and records are maintained .and are available for inspection.

Records of dressing renewals over a twelve week period were reviewed. On two occasions there was no record to evidence that wounds had been redressed. A recommendation is made that registered nurses should ensure that all prescribed nursing care is delivered and records maintained to evidence care delivery. Care records for the management of wounds during this period, reflected continued improvement and healing of wounds.

Care plans were in place for the management of challenging behaviour. There were additional charts which mapped episodes of challenging behaviour, any identified triggers or predisposing factors, intervention taken and the outcome. Discussion with staff and review of records evidenced that there was an awareness of the potential relationship between pain and challenging behaviour.

Overall care records were maintained to a good standard. To ensure care plan evaluations are enhanced they should include a meaningful statement of the patient's condition, including any changes, since the previous review. A recommendation has been made.

The inspectors observed care delivery and staff support of patients. 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.

Following discussion with staff, the inspectors were satisfied that a variety of options were available to transport patients to routine hospital appointments. The inspectors were assured that staff were considering the individual needs of each patient in their decision making. To ensure patients and their representatives are aware of the options available, for transporting patients to appointments outside of the home, a recommendation is made that the patient guide is updated..

Discussion with the registered manager evidenced that currently there were no vacancies for registered nurses within the home. There were four vacant posts for care assistants with a recruitment campaign in progress to fill these vacancies. Registered nurses spoken with were knowledgeable regarding the needs of the patients in their care and confirmed that there were good training opportunities available in the home and that they were supported with professional development by the registered manager.

Conclusion

The inspectors can confirm that at the time of this inspection the delivery of care to patients was evidenced to be of a good standard. Discussion with the registered manager, clinical lead and the registered nurse on duty demonstrated that they had a good awareness of the interventions required for patients with regard to the management of their physical and psychological needs. Staff spoken with were knowledgeable regarding the referral procedures in place for healthcare professionals in the local healthcare trust. There were processes in place to ensure the effective management of the areas of care inspected.

As a result of this inspection four recommendations have been made. These recommendations are detailed throughout the report and in the quality improvement plan (QIP).

The inspectors would like to thank the patients, registered manager, clinical lead nurse, registered nurses and staff for their assistance and co-operation throughout the inspection process.

4.0 Follow-up on the Requirements and Recommendations Issued as a Result of the Previous Secondary Unannounced Care Inspection conducted on 7 November 2014.

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	25(b)	Care records must be signed by the registered nurse completing them.	Review of care records evidenced that this requirement has been complied with.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
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.	Review of care records evidenced that this recommendation has been complied with.	Compliant
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.	Review of care records evidenced that this recommendation has been complied with.	Compliant

4.1 Follow-Up on any Issues/Concerns Raised with RQIA since the Previous Inspection such as Complaints or Safeguarding Investigations.

Since the previous care inspection on 7 November 2014, RQIA has been appropriately notified by the registered manager of referrals in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues.

On 23 January 2015 RQIA received written correspondence expressing concerns in the following areas:

- Management of nutrition
- Management of pain
- Addressing of expressed wishes by patients
- Staffing
- Transport arrangements for patients attending hospital appointments
- Patient dignity
- Communication with relatives.

It is not the remit of RQIA to investigate complaints made by or on behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a potential 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. On this occasion it was decided that an inspection would be undertaken.

The inspection focused on the management and delivery of care to those patients in the dementia unit. The inspectors reviewed the following areas:

- Care records
- Care practices
- General observation of care delivery
- Staffing
- Assessment of staff knowledge
- Review of staff training.

The inspectors concluded there were no regulatory breaches identified in respect of the areas which were examined. However, to enhance the processes already in place, areas for improvement were identified and recommendations have been made.

5.0 Inspection Focus

5.1 Care Records

Review of four care records evidenced that a comprehensive and detailed assessment of patient needs was completed. A variety of risk assessments, for example Braden Pressure Ulcer Risk Assessment, Abbey Pain Scale and the Malnutrition Universal Screening Tool (MUST) were also used to supplement the general assessment tool. The assessment of patient need was evidenced to inform the care planning process.

Care plans were in place to direct the care required for the assessed needs of each patient. Patient's care records generally evidenced that the care prescribed was being delivered. However in one patient's care records the care plan stated that the patient's blood pressure should be checked weekly. There was no evidence in the care records that this was being undertaken.

Care records for the management of wounds were reviewed. Wounds were graded using an evidenced based classification system and details of the wounds and frequency with which they required to be dressed were recorded in patients' care plans. Records of dressing renewals from 13 November 2014 to 4 February 2015, for one identified patient, evidenced two occasions in the twelve week period when there was no record to evidence that wounds had been redressed. Care records reflected continued improvement and healing of the wounds during this period.

Following review of care records it is recommended that nursing staff ensure that all prescribed nursing care is delivered and records maintained to evidence care delivery.

Patients' weights were recorded on admission and there after either monthly or weekly depending on individual need. Patients' nutritional risk assessments were reviewed regularly. Review of the records of weights of all patients in the home evidenced that appropriate action was taken in response to patients losing weight or eating excessively. There was evidence of patient referral to the dietetic services in the local health and social care trust. Records also evidenced referral to speech and language therapist (SALT) with regard to the management of swallowing difficulties.

Care plans were in place for the management of challenging behaviour. There were additional charts which mapped episodes of challenging behaviour, any identified triggers or predisposing factors, intervention taken and the outcome. The management of pain and the potential relationship between pain and challenging behaviour was discussed. A registered nurse evidenced that they had a sound awareness of pain management and provided an example of how the monitoring and recording of one patient's behaviour had informed a review of their pain relief with the GP.

Care plans were evaluated regularly. Review of the evaluation of care plans evidenced that some nurses were recording a meaningful evaluation including the care delivered and the patient's condition since the previous review. However, some care plan evaluations stated "no change at present". In one care plan there was a minor change to the patient's condition. The change did not require a change to the planned care however should have been referenced in

the care plan evaluation. It is recommended that care plan evaluations include a meaningful statement of the patient's condition, including any changes, since the previous review.

Discussion with the registered manager, clinical lead and the registered nurse on duty demonstrated that they had a good awareness of the interventions required for patients with regard to the management of their physical needs, for example weight loss, wound management, diabetes and hypertension. Staff spoken with were knowledgeable regarding the referral procedures in place to obtain advice and guidance from healthcare professionals, for example speech and language therapists, dieticians, occupational therapists and tissue viability nurses, in the local healthcare trust.

Registered nursing staff on day and night duty recorded statements to reflect the care and treatment provided to each patient. Additional entries were made throughout the registered nurses span of duty to reflect changes in the patients' status or to indicate communication with other professionals and/ or relatives/representatives concerning the patients. The daily communication notes were detailed and were patient centred. They contained good detail of the care delivered on a daily basis and the patients' physical and psychological state.

Care records contained evidence that the referring health and social care trust (HSCT) maintained appropriate reviews, a minimum of annually. These reviews were also held at the request of the registered manager in response to the changing needs of patients.

The inspectors reviewed two completed life history books entitled "About Me" which included who the patient wanted to be involved in their care and the people, places and events that were important to the individual patient. A section in the booklet asked patients to identify anything they required to assist them in the home. The registered manager explained that any request would be considered and discussed with the patient and relevant parties. There were no requests recorded on the completed books reviewed.

5.2 Care Practices and Observation of Care Delivery

On arrival to the home the inspectors noted that staff were well organised and care delivery was provided in a calm manner.

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. All patients were well groomed and appropriately dressed and appeared comfortable in their surroundings.

A daily patient meeting was introduced to the home a number of months ago. Since the previous inspection these meeting now take place in the dementia unit and the attendance has been extended to include the patients in this unit. The inspectors observed three patients from the dementia unit were outside with a member of staff attending to the chickens. The transport arrangements for patients attending routine hospital appointments were discussed. The inspectors were informed that a variety of options were available to consider depending on the type of appointment and the patients' individual needs. A policy entitled "Planning and Providing Transport for Residents," was in place. To ensure clear information is provided to patients and their representatives, it is recommended that the Patient Guide is updated to include the options available for transporting patients to appointments outside of the home.

As previously discussed patients weights were recorded on admission and there after either monthly or weekly depending on individual need. The servicing and calibration of the chair weighing scales was discussed with the registered manager who confirmed that the scales were included in the service agreement with a medical equipment provider. The contract also included maintenance and repair. Records evidenced that the scales were serviced in July 2014. There were no records of calibration available. It is recommended that patient weighing scales are calibrated in accordance with the manufacturer's instructions and records are maintained and available for inspection.

5.3 Staffing

Discussion with the registered manager evidenced that currently there were no vacancies for registered nurses within the home. There were four vacant posts for care assistants with a recruitment campaign in progress to fill these vacancies.

The management of registered nurses supplied from an employment agency was discussed with the registered manager. There were systems in place to ensure that agency staff were provided with an induction to the home and, as far as was practicable, registered nurses who know the home and the patients were requested. The registered manager confirmed that currently agency staff were only used in the event of staff sickness or to release staff to attended planned training.

5.4 Staff Training

The registered manager informed the inspectors that ten registered nurses were currently employed in the home qualified in either adult nursing or mental health nursing and that this provision of registered nurses provided a skill mix to meet both the physical and psychological needs of the patients accommodated.

Review of staff training records evidenced that in 2014 training had been attended by registered nurses in the following:

- Diabetes in healthcare
- Epilepsy management
- Falls prevention
- Prevention and management of violence and aggression
- Annual update on venepuncture.

Registered nurses spoken with during the inspection were knowledgeable regarding the needs of the patients in their care and confirmed that there were good training opportunities available in the home and that they were supported with professional development by the registered manager. Discussion with staff confirmed that there was an established system of appraisal within the home and that staff were encouraged to identified training and development needs as part of this process.

6.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Heather Maxwell, registered manager, 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:

Sharon McKnight
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Quality Improvement Plan

Secondary Unannounced Care Inspection

Apple Blossom Lodge

9 February 2015

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 Ms Heather Maxwell, registered manager, 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.

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	5.6	The registered manager should ensure that all prescribed nursing care is delivered and records maintained to evidence care delivery. **Ref section 5, 5.1**	One	All prescribed nursing care is delivered and records now evidence this.	From the date of inspection.
2	5.7	Care plan evaluations should include a meaningful statement of the patient's condition, including any changes, since the previous review. **Section 5, 5.1**	One	Care plan evaluations now show a more detailed summary supporting decision making around care and planning.	From the date of inspection.
3	3.1	The Patient Guide should be updated to include the options available for transporting patients to hospital appointments. **Ref section 5, 5.2**	One	The patient guide has been updated to include the options available for transporting patients to hospital appointments.	By the end of March 2015.
4	32.8	Patient weighing scales should be calibrated regularly and records maintained. **Ref section 5, 5.2**	One	Weighing scales are now calibrated more regularly and records of this are kept in the clinical room.	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	24-03-15
Further information requested from provider			