



Unannounced Care Inspection Report

21 January 2021



Prospect Nursing Home

Type of Service: Nursing Home (NH)

Address: 3 Old Galgorm Road, Ballymena, BT42 1AL

Tel No: 028 2564 5813

Inspector: Michael Lavelle

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.0 What we look for



2.0 Profile of service

This is a nursing home registered to provide nursing care for up to 50 persons.

3.0 Service details

Organisation/Registered Provider: Prospect Private Nursing Home Ltd Responsible Individual: Thomas Mark McMullan	Registered Manager and date registered: 01 April 2005
Person in charge at the time of inspection: Elizabeth Jane Ross	Number of registered places: 50
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment.	Number of patients accommodated in the nursing home on the day of this inspection: 37

4.0 Inspection summary

An unannounced inspection took place on 21 January 2021 from 10.15 hours to 15.15 hours. Due to the coronavirus (COVID-19) pandemic the Department of Health (DOH) directed RQIA to prioritise inspections to homes on the basis of risk.

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the service was well led.

The following areas were examined during the inspection:

- staffing
- care delivery
- care records
- infection prevention and control (IPC) measures
- leadership and governance.

Patients said they were happy living in the home. Examples of their comments are included in the main body of the report.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	0

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Elizabeth Jane Ross, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report.

During the inspection we met with seven patients, two patient's relatives and five staff. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. A poster was also displayed for staff inviting them to provide feedback to RQIA on-line. The inspector provided the deputy manager with 'Tell Us' cards for distribution to residents' relatives not present on the day of inspection to give an opportunity to give feedback to RQIA regarding the quality of service provision. Five patients and one relative questionnaire were returned.

The following records were examined during the inspection:

- staff duty rota for the weeks commencing 11 January 2021 and 18 January 2021
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- care records for three patients
- supplementary care charts, including food and fluid intake and repositioning
- accident and incident reports
- record of complaints and compliments
- records of audit including equipment cleaning records
- monthly monitoring reports for the period October 2020 to December 2020

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from previous inspections

The most recent inspection of the home was an unannounced care inspection undertaken on 11 February 2020.

The quality improvement plan from the previous inspection was not reviewed at this inspection. This will be reviewed at a future inspection.

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
<p>Area for improvement 1 Ref: Regulation 13 (1) (a)(b)</p> <p>Stated: First time To be completed by: Immediate action required</p>	<p>The registered person shall ensure the following in relation to the provision of wound care for all patients</p> <ul style="list-style-type: none"> • Care plan(s) are in place which prescribe the required dressing regimen and/or refer to such directions as are evidenced within any relevant multi-professional recommendations which should be available within the patient's care record. • Nursing staff shall record all wound care interventions in an accurate, thorough and consistent manner in compliance with legislative and best practice standards. • Nursing staff record a meaningful evaluation of the care delivered in relation to wound care. • A robust governance process is implemented to ensure that wound care within the home is effectively delivered to patients in accordance with their assessed needs, care standards and current best practice. <p>Ref: 6.2</p>	<p>Met</p>
	<p>Action taken as confirmed during the inspection: Review of care records for one identified patient and records of audit confirmed this area for improvement has been met.</p>	

<p>Area for improvement 2</p> <p>Ref: Regulation 16</p> <p>Stated: First time</p> <p>To be completed by: Immediate action required</p>	<p>The registered person shall ensure that initial care plans are developed for newly admitted patients from day one of admission to guide staff in the immediate delivery of care. The care plan should be further developed within five days of admission. Patient plans should be reviewed and updated in response to the changing needs of the patient. All evaluations of care should be meaningful and patient centred.</p> <p>Ref: 6.2</p>	<p>Met</p>
<p>Action taken as confirmed during the inspection: Review of care records for a patient recently admitted to the home evidenced that this area for improvement has been met.</p>		
<p>Area for improvement 3</p> <p>Ref: Regulation 13 (7)</p> <p>Stated: First time</p> <p>To be completed by: Immediate action required</p>	<p>The registered person shall ensure suitable arrangements are in place to minimise the risk/spread of infection between residents and staff. This area for improvement is made in reference to the issues highlighted in 6.2.</p> <p>Ref: 6.2</p>	<p>Met</p>
<p>Action taken as confirmed during the inspection: Observation of staff practices confirmed the deficits identified at the previous care inspection had been satisfactorily addressed. This area for improvement has been met.</p>		

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		Validation of compliance
Area for improvement 1 Ref: Standard 11 Stated: First time To be completed by: 11 March 2020	The registered person shall ensure individual activity assessments are completed for all patients. These should inform a person centred plan of care which is reviewed as required. Daily progress notes should reflect patient's activity provision. Activities provided in the home should be reviewed at least twice a year. Ref: 6.2	Met
	Action taken as confirmed during the inspection: Review of a selection of care records and discussion with the manager confirmed this area for improvement has been met.	

6.2 Inspection findings

6.2.1 Staffing

A system was in place to identify appropriate staffing levels to meet the patients' needs. A review of the staff rotas for the week of the inspection confirmed that the staffing numbers identified were provided. Observations on the day of the inspection confirmed that patients' needs were met by the staff on duty.

Patients told us the following:

"The care is good. Everything is great and it's a beautiful place. "

"The staff are sound. "

We spoke with five members of staff, who displayed commitment and empathy towards the patients; they had a good knowledge and understanding of patients' individual needs, wishes and preferences. All of the staff spoke compassionately of the impact of the current COVID 19 pandemic on staff, patients and relatives. Staff said that there was good team working and that there was effective communication between staff and management. Staff also told us the following:

"We are doing ok. It has been challenging (the pandemic) but we are all working together."

"The staff here are very good to the residents. They are all very good and we work well together. There is good teamwork."

Arrangements were in place to ensure that newly appointed staff received training as part of their induction to the home.

6.2.2. Care delivery

We walked around the home mid-morning. The atmosphere in the home was relaxed and well organised. Patients were either being cared for in their individual bedrooms or in the lounge areas. Patients were supported by staff to adhere to social distancing where possible. Patients appeared warm and comfortable. They were nicely dressed with good attention to detail with their personal care needs evident.

Patients told us:

“It’s lovely here. ”

“I’m ok.”

“It’s great but they are feeding me too well. ”

Two relatives spoken with told us:

“Visiting is well organised. The care is good. ”

“I am happy with the care here. We have had to be flexible as the visiting changes.”

We provided questionnaires in an attempt to gain the views of relatives, patients and staff that were not available during the inspection; six were received within the timeframe for inclusion in this report. Patient’s told us:

“You get good care in here. Staff are good. You are well looked after. ”

“Some things could be attended better. There is good care however when something is requested it would be good to have it dealt with promptly rather than much later. ”

“First class attention. Staff are very nice and mannerly. ”

“Prospect is now my home and I am quite comfortable here. It is a good home. ”

One negative comment received was feedback to the manager for action as required. Any comments from patients, patient representatives and staff in returned questionnaires received after the return date were shared with the manager for their information and action as required.

We spoke with the activity leader post inspection and discussed the provision of activities and the challenges of delivering a programme in the current pandemic. They were very positive about their role and review of records confirmed they completed an individual activity assessment for patients.

On the day of the inspection planned visits were taking place in the home with the assistance of staff to facilitate social distancing. Precautions such as a booking system, temperature checks and provision of PPE were in place for visitors to minimise the risk of the spread of infection. Systems such as video calls and regular telephone calls between the home, patient and their relatives were also in place.

We saw patients enjoying their lunch in the lounges of the home or their bedrooms. During our walk around the home mid-morning and after lunch we saw staff had their breaks in the patient’s dining room. This was discussed with the manager who advised that staff did not have a designated area where they could effectively social distance and described how they had their meals within the patients’ dining room. We discussed the importance of implementing zones within the home for staff to ensure that the regional COVID-19 guidance is adhered to. The manager agreed to review this arrangement. This will be reviewed at a future care inspection.

The home had received numerous letters and cards of support throughout the current pandemic. The following are examples of some of the comments recorded in these letters and cards:

“We want to thank you for caring for our mum so lovingly. It was a joy to visit in the home that became hers. ”

“Thank you so much for your kind and loving care. ”

6.2.3 Care records

A range of assessments, to identify each patient’s needs, were completed on admission to the home; from these assessments care plans to direct the care and interventions required were produced. Other healthcare professionals, for example speech and language therapists (SALT) and dieticians also completed assessments as required. The outcomes of these assessments were available in the patients’ notes.

Staff were well informed with regard to patients’ needs, what areas patients were independent with and the level of assistance they required in daily life. Staff encouraged choice and independence.

We reviewed three patients’ care records which evidenced that care plans were person centred and reviewed regularly. Patients’ weights were kept under review and checked monthly to identify any patient who had lost weight. Records of patients’ food and fluid intake were recorded daily. Minor deficits in record keeping were identified on review of care documentation. This was discussed with the manager for action as required.

We reviewed patients’ needs in relation to wound prevention and care. Records confirmed that the wound was dressed in keeping with the care plan instructions. A wound assessment and a meaningful evaluation were completed every time the wound was redressed.

We examined the management of patients who had falls. Review of one unwitnessed fall evidenced appropriate actions were not consistently taken following the fall in keeping with best practice guidance. This was discussed with the manager and an area for improvement was made.

6.2.4 Infection prevention and control (IPC) measures

On arrival to the home we were met by a member of staff who recorded our temperature; hand sanitiser and PPE were available at the entrance to the home. Signage had been placed at the entrance to the home which provided advice and information about Covid-19.

We found that there was an adequate supply of PPE and no issues were raised by staff regarding the supply and availability of PPE. Staff spoken with knowledgeable of the correct use of PPE, wore face masks appropriately and were observed applying and removing PPE; and were appropriate with their use of hand sanitising gel and hand washing. There were numerous laminated posters displayed throughout the home to remind staff of good hand washing procedures and the correct method for applying and removing of PPE. Audits, including hand hygiene and use of PPE, were completed monthly and evidenced good compliance with best practice.

Staff confirmed that enhanced cleaning arrangements were in place and included a daily schedule for the cleaning of touchpoints such as door handles, light switches and hand rails. The manager explained that the amount of domestic hours had been increased to facilitate enhanced cleaning. Staff also confirmed that bedrooms where patients were self-isolating were cleaned last.

6.2.5 Leadership and governance

There was a clear management structure within the home and the manager was available throughout the inspection process. The manager retained oversight of the home and was supported by the nursing sister. Staff commented positively about the manager and described her as supportive, approachable and available for guidance and support.

We looked at the records of accidents and incidents which occurred in the home; we found that not all head injuries had been reported appropriately. This was discussed with the manager who completed an audit of accidents and incidents since the last care inspection and submitted all outstanding notification retrospectively. Clarity was provided to the manager regarding notification of head injuries.

Review of one staff recruitment file confirmed staff were recruited safely to ensure they were suitable to work with vulnerable patients. Review of records confirmed systems were in place to monitor staffs' registrations with their relevant professional bodies. The manager confirmed that staff training was actively managed. Appropriate records were maintained. Review of the training matrix confirmed fire training was outstanding for some staff. The manager agreed to have all staff complete fire training by the second week in February 2021.

We reviewed records which confirmed that there was a system of audits which covered areas such as falls, dependencies, IPC, hand hygiene, care records and accidents and incidents. These audits were designed to ensure that the manager had full oversight of all necessary areas.

We examined the reports of the visits by the registered provider for August and September 2020. All operational areas of the management of the home were covered. Where any issues were identified, an action plan was developed which included timescales and the person responsible for completing the action.

Areas of good practice

Areas of good practice were identified with regard to staff commitment to patient care, care delivery and activities, the provision and usage of PPE and effective team work throughout the home.

Areas for improvement

One new area for improvement was identified in relation to falls management.

	Regulations	Standards
Total number of areas for improvement	1	0

6.3 Conclusion

The atmosphere in the home was relaxed and well organised. Staff were timely in responding to patients individual needs.

The home was clean, tidy and fresh smelling; recommended IPC measures were followed and staff used PPE according to the regional guidance.

Observations of care delivery, discussion with staff and a review of records provided assurances that the care in Prospect was safe, effective, compassionate and well led.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Elizabeth Jane Ross, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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 the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005

<p>Area for improvement 1</p> <p>Ref: Regulation 13 (1) (a) (b)</p> <p>Stated: First time</p> <p>To be completed by: With immediate effect</p>	<p>The registered person shall ensure that nursing staff carry out clinical/neurological observations, as appropriate, for all patients following a fall and that all such observations/actions taken post fall are appropriately recorded in the patient's care record.</p> <p>Ref: 6.2.3</p>
	<p>Response by registered person detailing the actions taken: CNS observations carried out as appropriate. Introduction of a falls checklist and more in depth auditing to ensure documentation is recorded appropriately.</p>

Please ensure this document is completed in full and returned via Web Portal



The Regulation and Quality Improvement Authority

9th Floor

Riverside Tower

5 Lanyon Place

BELFAST

BT1 3BT

Tel 028 9536 1111

Email info@rqia.org.uk

Web www.rqia.org.uk

 [@RQIANews](https://twitter.com/RQIANews)