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Unannounced Care Inspection
of
Prospect

07 December 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1. Summary of Inspection

An unannounced care inspection took place on 07 December 2015 from 09:15 to 16:45.

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

Overall on the day of the inspection, concerns and areas of improvement were identified and are required to be addressed to ensure that care in the home is safe, effective and compassionate. These areas are set out in the Quality Improvement Plan (QIP) within this report. Refer also to section 1.2 below.

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

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 30 November 2014.

1.2 Actions/Enforcement Resulting from this Inspection

An urgent action record regarding the use of restrictive practices and patients' repositioning records was issued to Sinead Kerr, nurse in charge, at the end of the inspection. These actions are required to be addressed without delay to ensure the safety and wellbeing of patients in the home.

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

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	*2	4

* The total number of requirements above includes both new and those that have been 'restated'.

The details of the Quality Improvement Plan (QIP) within this report were discussed with Sinead Kerr, nurse in charge as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Prospect Private Nursing Home Ltd. Thomas Mark McMullan	**Registered Manager:** Elizabeth Jane Ross
Person in Charge of the Home at the Time of Inspection: Sinead Kerr	**Date Manager Registered:** 1 April 2005
Categories of Care: NH-I, NH-PH	**Number of Registered Places:** 52
Number of Patients Accommodated on Day of Inspection: 48	**Weekly Tariff at Time of Inspection:** £609 - £668

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standards and theme have been met:

Standard 19: Communicating Effectively
Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

4. Methods/Process

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

Prior to inspection the following records were analysed:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre-inspection assessment audit.

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with six patients, one domestic staff, four care staff, two nursing staff, two visiting professionals and four patient's representatives.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- eight patient care records
- staff training records
- complaints records
- policies for communication and end of life care
- policies for dying and death and palliative and end of life care.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection dated 17 November 2015.

The previous inspection of the home was an unannounced estates inspection dated 17 November 2015. The completed QIP was returned and approved by the estates inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection on 30 November 2014.

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 15 (2) (a) **Stated:** First time	The registered manager should ensure that bladder and bowel continence assessments have been undertaken for all patients. The outcome of these assessments, including the type of continence products to be used, should be incorporated into the patients' care plans on continence care. Assessment of the patients' needs should be kept under review and revised at any time when it is necessary to do so having regard to any changes in the patients' condition.	
	Action taken as confirmed during the inspection: A review of eight patient care records evidenced that continence assessments were not in place for five patients and bowel assessments were not completed in any of the care records reviewed. This requirement was not met and has been stated for the second time. Refer to inspector comments in section 5.5 for further details.	**Not Met**

<table>
<tr><th colspan="2">Last Care Inspection Recommendations</th><th>Validation of Compliance</th></tr>
<tr><td rowspan="2">Recommendation 1

Ref: Standard 12.1

Stated: First time</td><td>It is recommended that the registered manager ensures that a fluid intake target is established for those patients assessed as being at risk, based on their individual needs and in accordance with best practice guidelines.

Corresponding fluid intake charts and care plans should reflect individualised patient need and ensure the following:

• the total fluid intake for the patient over 24 hours
• an effective reconciliation of the total fluid intake against the fluid target established
• action to be taken if targets are not achieved
• a record of reconciliation of fluid intake in the daily progress notes.</td><td rowspan="2">Partially Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A review of the daily progress notes evidenced that the total fluid intake for the patients was being monitored and fluid targets were generally recorded in the patients care plans. However, a review of five fluid intake monitoring charts evidenced that fluid intakes were not being recorded contemporaneously. Therefore, this recommendation was only partially met and a new recommendation was made regarding the need for fluid intake records to be maintained contemporaneously.</td></tr>
</table>

Recommendation 2 **Ref**: Standard 19.2 **Stated:** First time	It is recommended that a policy and procedure be developed on urinary catheterisation and catheter care. The following guidelines should also be readily available to staff and used on a daily basis: • RCN continence care guidelines • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence.	**Met**
	Action taken as confirmed during the inspection: A policy on urinary catheterisation and catheter care had been reviewed following the last inspection. The guidelines, listed above, were also available on the day of inspection.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

The home's policy on breaking bad news, issued in January 2009 was reviewed and reflected current best practice, including regional guidelines on Breaking Bad News. However, the policy did not include the procedure for breaking bad news in the event of an unexpected death. A recommendation was made in this regard.

A review of the staff's training records evidenced that 40 out of 46 staff had completed training in relation to communicating effectively with patients and their families/representatives. The training content of this training was not available for inspection; however, the nurse in charge confirmed that the training did include the procedure for breaking bad news as relevant to staff roles and responsibilities. Discussion with one registered nurse and care staff confirmed that staff were aware of the sensitivities around breaking bad news and the importance of accurate and effective communication.

Is Care Effective? (Quality of Management)

The registered nurses demonstrated their ability to communicate sensitively with patients and relatives when breaking bad news and provided examples of how they had done this in the past. They explained that there were events which would trigger sensitive conversations with patients and/or their families, for example, an increase in the number of admissions to hospital, and/or reoccurring symptom with a poor prognosis. They emphasised the importance of building caring relationships with patients and their representatives and the importance of regular, ongoing communication regarding the patient's condition.

Care staff considered the breaking of bad news to be primarily, the responsibility of the registered nursing staff, but felt confident that, should a patient choose to talk to them about a diagnosis or prognosis of illness, they would have the necessary skills to do so. They also felt their role was to empathise and to support patients and their representatives following sensitive or distressing news.

Is Care Compassionate? (Quality of Care)

Discussion with four patients individually and with the majority of patients generally, evidenced that patients were content living in the home. Observations of the delivery of care and staff interactions with patients confirmed that communication was well maintained and patients were observed to be treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully.

Staff recognised the need to develop a strong, supportive relationship with patients and relatives. It was appreciated by staff that this relationship would allow the delivery of bad news more sensitively and with greater empathy when required.

All patient's representatives consulted also confirmed that they were kept informed of any changes to their relative's condition and of the outcome of visits and reviews by healthcare professionals. There were several cards and letters on display complimenting the care that was afforded to patients when they were receiving end of life care.

Areas for Improvement

A policy on communicating effectively in line with current best practice, such as DHSSPSNI (2003) *Breaking Bad News,* should be further developed and which should include the procedure for breaking bad news in the event of a sudden or unexpected death.

Number of Requirements:	**0**	**Number of Recommendations**: ***1 recommendation made is stated under Standard 32 below**	**1**

5.4 Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

Is Care Safe? (Quality of Life)

Policies and procedures on the management of palliative and end of life care and death and dying were available in the home. However, the policies did not reflect best practice guidance such as the GAIN Palliative Care Guidelines, November 2013. It was concerning that the policy on the care of the dying and deceased resident stated that the "Liverpool pathway should be used". The nurse in charge provided assurances that all staff were aware that the Liverpool Care Pathway was no longer in use. The policies also did not include the procedures for referring patients for specialist palliative care, the management of shared rooms or the management of an unexpected death. A recommendation was made.

There was no formal protocol for timely access to any specialist equipment or drugs in place.

However, discussion with one registered nurse confirmed their knowledge of local arrangements for accessing palliative care teams, district nursing teams, GP out-of-hours or pharmacists, if required.

A review of staff training records evidenced that all staff had completed recent training in death, dying and bereavement and palliative and end of life care. Registered nursing staff and care staff were aware of and able to demonstrate knowledge of the GAIN Palliative Care Guidelines, November 2013. The review also evidenced that five out of 15 registered nurses had attended recent training in the use of syringe drivers and that there was one registered nurse who had completed the train the trainer programme. There was no nominated palliative care link nurse identified. However, the nurse in charge stated that she would undertake this role when training becomes available.

Discussion with two nursing staff and a review of six care records confirmed that:

- there were arrangements in place for staff to make referrals to specialist palliative care services
- staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken.

Is Care Effective? (Quality of Management)

A review of six care records evidenced that patients' needs for palliative and end of life care were assessed and reviewed on an ongoing basis. This included the management of hydration and nutrition, pain management and symptom management. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements. There was evidence in four care records that the patient's wishes and their social, cultural and religious preferences were also considered and were included in the care plan. However, the care plans reviewed were generic and did not reflect any aspect of person-centred-ness. A recommendation was made.

A key worker/named nurse was identified for each patient approaching end of life care.

Management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying. Through discussion there was evidence that staff had managed shared rooms appropriately.

Discussion with the nurse in charge, staff and a review of the care records evidenced that environmental factors had been considered. One compliments record reviewed specifically included gratitude for the staffs efforts at 'creating the perfect temperature' for the patient who was nearing end of life, by 'layering on and taking off blankets. This is to be commended.

A review of notifications of death to RQIA during the previous inspection year evidenced that all records were maintained appropriately.

Is Care Compassionate? (Quality of Care)

Discussion with staff and a review of the care records evidenced that patients and/or their representatives had been consulted in respect of their cultural and spiritual preferences regarding end of life care. All staff consulted demonstrated an awareness of patient's expressed wishes and needs as identified in their care plan.

Arrangements were in place in the home to facilitate, as far as possible, in accordance with the persons wishes, for family/friends to spend as much time as they wish with the person. Overnight stays were facilitated where possible and staff consulted described how catering/snack arrangements would be provided to relatives during this period. One compliments record specifically thanked the staff for the numerous cups of tea they were offered, which helped make a difficult time easier to bear.

From discussion with the manager, staff and a review of the compliments record, there was evidence that arrangements in the home were sufficient to support relatives during this time. There was evidence within compliments/records that relatives had commended the management and staff for their efforts towards the family and patient.

Discussion with the nurse in charge and a review of the complaints records evidenced that no concerns were raised in relation to the arrangements regarding the end of life care of patients in the home.

All staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death. From discussion with the manager and staff, it was evident that arrangements were in place to support staff following the death of a patient. The arrangements included more experienced staff supporting staff who were new to the role and time spent reflecting on the patients' time spent living in the home.

Information regarding support services was available and accessible for staff, patients and their relatives. This information included a booklet from the hospice regarding what to expect when someone important to you is dying. Advice was given regarding additional sources of information that are available.

Areas for Improvement

The policy on palliative and end of life care should be further developed in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines and should include the* referral procedure for specialist palliative care nurses; the procedure for managing shared rooms; and the management of a sudden or unexpected death.

Where a decision is made regarding end of life care, a person-centred care plan should be developed and should include identified religious, spiritual and cultural needs.

Number of Requirements:	**0**	**Number of Recommendations:**	**2**

5.5 Additional Areas Examined

Care Records

A review of eight patient care records evidenced that continence assessments were not in place for five patients and bowel assessments were not completed in any of the care records reviewed. Furthermore, one patient was identified as having two continence assessments in place, both with different scores. There was also no evidence within the records that the outcome of continence assessments were incorporated into the patients' care plans on continence care. This was evident in one care record where a patient was identified as being at high risk for constipation; however, the patients care plan for continence did not include any reference to the patient's normal bowel pattern. A review of another patient's care record did not evidence any monitoring of bowel function for an 8 day period before being addressed. As discussed in section 5.2, a requirement was previously been made and was stated for the second time.

On the first floor, there between 14 and 16 patients observed in bed during the inspection. Repositioning records were only available for two patients. The staff consulted advised that many of the patients returned to bed in the afternoon for a rest period and that many of whom could independently move around the bed. However, a review of 15 patients' assessments evidenced that five patients had been assessed as being at high risk for developing pressure ulcers, using the Braden assessment tool. One patient, who was identified as having grade two pressure damage, also did not have any position change recorded for a six hour period. This was discussed with thee nurse in charge during feedback. An urgent actions record was issued at time of inspection in regard to the matters outlined above. A requirement was also made to ensure that repositioning records are maintained for patients who are assessed as being at risk for developing pressure ulcers.

A review of the daily progress notes evidenced that the total fluid intake for the patients was being monitored and fluid targets were generally recorded in the patients care plans. However, a review of five fluid intake monitoring charts evidenced that fluid intakes were not being recorded contemporaneously. A recommendation was made in this regard.

Care Practices

Eleven patients were observed seated in transit wheelchairs with lap belts fastened, which posed a potential risk of entrapment. The care assistants consulted advised that the lap belts were only secured during patient transit. This was brought to the attention of the nurse in charge to address as a matter of urgency. Staff did attend to the lap belts of the patients. However, later during the inspection seven patients were observed to have their lap belts fastened for extended periods with no staff present. This was again brought to the attention of staff and management to be addressed urgently. An urgent actions record was issued at time of inspection in regard to the matters outlined above. A requirement was also made to ensure that patients are not restrained unless as a last resort and as agreed by the multi-disciplinary team and recorded in accordance with best practice guidance on the management of restraint.

The majority of patients who ate in the dining room were seated in transit wheelchairs. The care assistants consulted advised that this was the patients' choice. However, a review of the care records did not evidence that patients and or their representatives had been consulted. A recommendation was made to ensure that where decisions are made for patients to eat their meals, whilst seated in a transit wheelchair, this information should be recorded in the patient's care plan.

Questionnaires

As part of the inspection process we issued questionnaires to staff, patients and their representatives.

Questionnaire's issued to	Number issued	Number returned
Staff	11	9
Patients	5	5
Patients representatives	5	4

All comments on the returned questionnaires were in general positive. Some comments received are detailed below:

Staff

'I find Prospect to be a very good home, well organised with good supervision and care'
'The care here is as good as (the care in the Macmillan Unit)'
'A good quality of care is provided that you would hope your own friends and family would receive'
'I think this home (has) much higher standards and quality of care, especially end of life care'
'I love working here and am happy to know that each resident is getting the best care possible'
'As colleagues we work well together and can express any concerns. This is carried forward to the residents, who know they can also talk to us'
'High quality of care given to the residents'
'The management run a good team. Every patient is treated as an individual and the person that they are'

Patients

'I feel happy, safe, relaxed and secure'
'It's the next best thing to home'
'I am happy at present'
'They are every attentive and kind'
'I am getting on brilliantly well. It is like returning home'
'It is very good. The (nurses) are kind'

Patients' representatives

'I have had two relatives live in this home. The quality in every aspect is excellent'
'This is a beautiful and very well kept nursing home. The nursing care is second to none'
'It is very reassuring …. to see the respect that is shown to patients'
'The staff are always happy and cheerful'

'The staff are exceptionally kind and efficient. My (relative's) admission here …. was handled with exceptional compassion and efficiency, shown not only to my (relative) but also to me'

Environment

A general tour of the home was undertaken which included review of a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout.

Areas for Improvement

Repositioning records must be maintained for all patients who are assessed as being at risk for developing pressure ulcers.

Fluid intake monitoring charts should be recorded contemporaneously.

Patients must not be restrained unless as a last resort and as agreed by the multi-disciplinary team and recorded in accordance with best practice guidance on the management of restraint.

Where decisions are made for patients to eat their meals, whilst seated in a transit wheelchair, this information should be recorded in the patient's care plan.

Number of Requirements:	**2**	**Number of Recommendations:**	**2**

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Sinead Kerr, nurse in charge, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person/manager to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Care Standards for Nursing Homes, April 2015. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained in this report do not absolve the registered provider/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered provider/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan

Statutory Requirements	
Requirement 1 **Ref:** Regulation 15 (2) (a) **Stated:** Second time **To be Completed by:** 04 February 2015	The registered manager should ensure that bladder and bowel continence assessments have been undertaken for all patients. The outcome of these assessments, including the type of continence products to be used, should be incorporated into the patients' care plans on continence care. Assessment of the patients' needs should be kept under review and revised at any time when it is necessary to do so having regard to any changes in the patients' condition. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Continence and constipation assessments completed and will be reviewed and updated as necessary. Outcomes of assessments to be incorporated into patients care plans.
Requirement 2 **Ref:** Regulation 13 (1)(a) **Stated:** First time **To be Completed by:** 04 February 2015	It is required that the home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients. It is therefore required that where nursing needs are identified care must be delivered to ensure individual patient needs are met, in particular, focus must be made on the maintenance of repositioning records for all patients who are assessed as being at a high risk of pressure sore development. An urgent actions record was issued. **Ref: Section 5.5**
	Response by Registered Person(s) Detailing the Actions Taken: Repositioning charts now in place for any patients who have been assessed as high risk for pressure sore development.
Requirement 3 **Ref:** Regulation 14 (4) (5) (6) **Stated:** First time **To be Completed by:** 04 February 2015	The registered person must ensure that arrangements are in place to ensure that patients are not restrained unless it is agreed by the multidisciplinary team and recorded in accordance with best practice guidance on restraint. An urgent actions record was issued. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Lap belts used in the transit of patients are unfastened when stationary. Any other restraint is agreed by MDT and recorded.

Recommendations	
Recommendation 1 **Ref**: Standard 32.1 **Stated:** First time **To be Completed by:** 04 February 2015	The following policies and guidance documents should be developed and made readily available to staff: A policy on communicating effectively in line with current best practice, such as DHSSPSNI (2003) *Breaking Bad News,* which should include the breaking bad news in the event of a sudden or unexpected death. A policy on palliative and end of life care in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines which* should include the: • referral procedure for specialist palliative care nurses; • procedure for managing shared rooms; and • management of a sudden or unexpected death. **Ref: Section 5.3 and 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: Policies are currently under review and will reflect current best practice and regional guidance.
Recommendation 2 **Ref**: Standard 32.1 **Stated:** First time **To be Completed by:** 04 February 2015	Where a decision is made regarding end of life care, a person-centred care plan should be developed and should include identified religious, spiritual and cultural needs. **Ref: Section 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: Care plans reviewed to reflect a person centred appraoch to end of life care.
Recommendation 3 **Ref**: Standard 37.4 **Stated:** First time **To be Completed by:** 04 February 2015	The process for recording food/fluid intake and repositioning is reviewed, to ensure that entries are recorded at the time care is delivered. **Ref: Section 5.2 and 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Processes reviewed and staff recording charts contemporaneously.

Recommendation 4 **Ref**: Standard 4.1 **Stated:** First time **To be Completed by:** 04 February 2015	Where decisions are made for patients to eat their meals, whilst seated in a transit wheelchair, this information should be recorded in the patient's care plan. **Ref: Section 5.5** **Response by Registered Person(s) Detailing the Actions Taken:** Risk assessments and care plans updated to reflect patients decisions in relation to eating whilst seated in a wheelchair

Registered Manager Completing QIP	Mrs Liz Ross	**Date Completed**	01/02/16
Registered Person Approving QIP	Mr Mark McMullan	**Date Approved**	01/02/16
RQIA Inspector Assessing Response	Aveen Donnelly	**Date Approved**	02/02/2016

Please ensure this document is completed in full and returned to Nursing.Team@rqia.org.uk from the authorised email address