Unannounced Care Inspection Report
11 February 2020

Prospect

Type of Service: Nursing Home
Address: 3 Old Galgorm Road, Ballymena BT42 1AL
Tel No: 028 25 645813
Inspector: Michael Lavelle

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 registered nursing home which provides care for up to 50 patients.

3.0 Service details

Organisation/Registered Provider: Prospect Private Nursing Home Ltd **Responsible Individual(s):** Thomas Mark McMullan	**Registered Manager and date registered:** Elizabeth Jane Ross – 1 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:** 40

4.0 Inspection summary

An unannounced care inspection took place on 1 February 2020 from 10.40 hours to 16.00 hours.

The inspection assessed progress with all areas for improvement identified in the home since the last premises inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to the culture and ethos of the home, maintaining patients' dignity and privacy and maintaining good working relationships.

Areas for improvement were identified in relation to wound management, developing care plans in a timely manner, evaluation of care, infection prevention and control practices and activities.

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.

Patients described living in the home in positive terms. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surroundings and in their interactions with staff.

Comments received from patients, people who visit them, visiting professionals and staff during the inspection, are included in the main body of this 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	3	1

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.

4.2 Action/enforcement taken following the most recent inspection dated 4 November 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 4 November 2019. No further actions were required to be taken following the most recent inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings, registration information, and any other written or verbal information received.

During our inspection we:

- where possible, speak with patients, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept.

A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were examined during the inspection:

- duty rota for all staff for week commencing 10 February 2020
- a sample of incident and accident records
- a sample of governance audits/records
- three patients' care records
- a selection of patient care charts including food and fluid intake charts and reposition charts
- a sample of reports of visits by the registered provider.

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 inspection dated 4 November 2019

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 21.1 **Stated:** First time	The registered person shall ensure care plans for the management of wounds accurately reflect recommendations of the multidisciplinary team. Care should be delivered in keeping with the assessed needs of the patient and evaluations should be in keeping with best practice guidance.	**Not met**
	Action taken as confirmed during the inspection: Review of care records for one identified patient evidenced this area for improvement has not been met. This is discussed further in 6.2. **This area for improvement has not been met and has been subsumed into a regulation.**	

6.2 Inspection findings

Staffing levels

Discussion with the manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. We noted the use of agency staff to cover vacant care assistant shifts. The manager confirmed recruitment is ongoing for care assistants.

A review of the duty rota for week commencing 3 February 2020 evidenced that the planned staffing levels were adhered to. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

We saw that there was sufficient staff on duty to meet the needs of patients. Patients and care staff we spoke with expressed no concerns regarding staffing levels in the home. One staff member said, "There are a lot of agency staff but they are regular."

Care records

We reviewed wound care for an identified patient who had two wounds. There was evidence of multidisciplinary involvement in the management of one of the wounds but not the other. It was noted that wound care planning was either inaccurate or inconsistent with the tissue viability nurses recommendations, with one care plan being used to manage two wounds. We asked the manager to consider taking photos of wounds to evidence improvement or deterioration in keeping with best practice guidance.

Review of wound care records demonstrated that one of the patient's wounds had not been assessed for up to nine days. We found that the evaluation of wound care by nursing staff lacked sufficient detail; nursing staff should ensure that they record a meaningful evaluation of any wound care provided. We noted the absence of a robust audit process to quality assure wound care delivery. Management of wounds was identified as an area for improvement during the inspection on 4 November 2019. This has been subsumed into a new area for improvement under regulation.

Care records for a recently admitted patient had not been fully developed to guide the staff in the delivery of daily care needs. Whilst there were records of assessment of patient need and associated risk assessments the care plans need to be improved to guide staff on a daily basis.

Deficits in evaluation of care and record keeping were identified on review of additional care records. Some of the records contained repetitive nursing entries with some evaluations of care not personalised. This had been identified during monthly monitoring reports. The October 2019 report noted that, "some records were more patient centred than others" while the November 2019 report stated that some progress notes were better than others. This was discussed with the manager who agreed to address this with registered nursing staff. An area for improvement was made.

Reviews of supplementary care charts such as food and fluid intake, repositioning and personal care records evidenced these were well completed. We commended staff for the contemporaneous recording of these records.

Care delivery

There was a pleasant, relaxed atmosphere in the home throughout the inspection; staff and patients had cheerful and friendly interactions. Patients were well presented, receiving support with personal care in a timely and discrete manner. Patients were comfortable around staff and in approaching them with specific requests or just to chat.

Staff were knowledgeable and adept at communicating with patients in both verbal and non-verbal styles. Patients who were unable to clearly verbally communicate were content engaging in their preferred activities. Any signs of discomfort or distress were promptly and effectively addressed by staff.

The staff we spoke with could describe the specific needs, interests and personalities of those who live in Prospect; there was a clear person centred focus in the home.

During review of the environment we observed some patients were unable use the nurse call bell system due to physical or cognitive impairment. This was discussed with the manager who agreed to audit all bedrooms to ensure that those patients who cannot use their nurse call bell

independently are appropriately supervised by staff at all times. This will be reviewed at a future care inspection.

The environment

A review of the home's environment was undertaken and included observation of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be clean, warm and fresh smelling throughout. Bedrooms were personalised depending on the needs and wishes of the patients. Fire exits and corridors were observed to be clear of clutter and obstruction.

Staff were knowledgeable in relation to best practice guidance with regards to hand hygiene and use of personal protective equipment (PPE). However, observation of practice evidenced deficits in infection prevention and control (IPC) practices specifically relating to hand hygiene and disposal of PPE. This was discussed with the manager who agreed to address the deficits identified to ensure best practice guidance is adhered to. An area for improvement was made.

Consultation

During the inspection we spoke with eight patients, one visitor, five visiting professionals and four staff. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with others. Patients said:

"It's lovely but it's not home."
"It's ok."
"They are terribly good to me in here. The lunch would have done the Queen."
"I go to activities the odd time, depending on what they are."
"I am very very happy here."
"It is terrific. It is so relaxing. They (the staff) organise your day for you."

The visitor spoke positively in relation to the care provision in the home. They said:

"It's first class. The staff are wild friendly."

The visiting professionals spoken with were complementary of the home. They said:

"From my perspective this is a gold standard for nursing homes. They are excellent."
"Very good. It is excellent."

Comments from staff spoken with during the inspection included:

"I love the homely atmosphere and the work. I am very well supported in my job."
"I like the team we work with. They all work really well together."
"I enjoy working here. The teamwork is very good."

Activity

The staff we spoke with had a good knowledge and understanding of the need for social and leisure opportunities to support patients' health and wellbeing. An activity planner was on display in the foyer and available in each patients bedroom. Patients spoken with said the enjoyed the activities in the home. One patient said, "I enjoy the quizzes and the char exercises."

We spoke with the activity therapist who was enthusiastic regarding their role. They spoke positively about a training day they were due to attend to develop them in their role. They had developed a newsletter for the home and plans were in place for collaborative work between the patients in the home and the local nursery school.

However, improvements in documentation could be made to evidence support of patients to engage in activities. We highlighted that patients' activity records should evidence how patients are supported by staff to engage in activities and also include an evaluation of activities undertaken on a regular and consistent basis. An area for improvement was made.

Management arrangements

There was evidence that the manager had effective oversight of the day to day running of the home. For example, a number of audits were completed to assure the quality of care and services. Areas audited included accidents and incidents, complaints and hand hygiene. Audits generated action plans that highlighted areas for improvement and there was evidence that the deficits identified were addressed, as required. Due to the deficits identified in wound care records we asked the manager to develop a robust audit process to quality assure wound care delivery.

Review of records evidenced that quality monitoring visits were completed on a monthly basis on behalf of the registered provider.

Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised.

Areas of good practice

Areas of good practice were identified in relation to the culture and ethos of the home, maintaining patients' dignity and privacy, and maintaining good working relationships.

Areas identified for improvement

Areas for improvement were identified in relation to wound management, developing care plans in a timely manner, evaluation of care, infection prevention and control and activities.

	Regulations	Standards
Total number of areas for improvement	3	1

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

Area for improvement 1 **Ref**: Regulation 13 (1) (a)(b) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure the following in relation to the provision of wound care for all patients: • 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. Ref: 6.2
	Response by registered person detailing the actions taken: Wound Care documentation and evaluations have been reviewed and updated. Review of the governance in place has been reviewed and adapted.
Area for improvement 2 **Ref**: Regulation 16 **Stated:** First time **To be completed by:** Immediate action required	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. Ref: 6.2
	Response by registered person detailing the actions taken: Staff reminded to develop and review care plans within a timely manner according to the regulations.
Area for improvement 3 **Ref**: Regulation 13 (7) **Stated:** First time **To be completed by:**	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.

Immediate action required	Ref: 6.2

	Response by registered person detailing the actions taken: Hand sanitser added to Dining Areas and staff practices observed and audits increased around dining times.
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
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
	Response by registered person detailing the actions taken: Review of activity assessments made and person centred plans carried out for each resident. Daily progress notes updated and reviewed to reflect residents activities.

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

The Regulation and Quality Improvement Authority

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

Assurance, Challenge and Improvement in Health and Social Care