Unannounced Care Inspection Report
15 March 2017

Prospect

Type of Service: Nursing Home
Address: 3 Old Galgorm Road, Ballymena, BT42 1AL
Tel no: 028 2564 5813
Inspector: Bridget Dougan

1.0 Summary

An unannounced inspection of Prospect Nursing Home took place on 15 March from 11.30 to 14.30.

The inspection sought to assess progress with issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

The focus of the inspection was nutrition, meals and mealtimes.

Is care safe?

There was evidence of competent and safe delivery of care on the day of inspection. A recommendation has been made for a review of the policy on meals and mealtimes. Staff, patients and the majority of relatives expressed no concerns regarding staffing levels. One relative who completed a questionnaire indicated some concerns regarding a delay in assisting patients to the toilet. This was referred to the registered manager for follow up. A recommendation has also been made for all relevant staff to be provided with update training in feeding techniques for patients who have swallowing difficulties.

Is care effective?

Care records reflected the assessed needs of patients' were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals.

There was evidence that the care planning process included input from patients and/or their representatives, as appropriate.

Each staff member understood their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the nurse in charge or the registered manager. A recommendation has been stated for the second time in respect of staff meetings.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Patients were given a choice in regards to food and fluid choices and the level of help and support requested.

Patients spoken with were complimentary regarding the care they received and life in the home.

There were no requirements or recommendations made.

Is the service well led?

Systems were in place to monitor and report on the quality of nursing and other services provided. Complaints, incidents and accidents were managed in accordance with legislation.

Staff confirmed that management were responsive to any suggestions or concerns raised. A recommendation has been stated for the second time in respect of the audits of care records.

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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	4*

* The recommendations above include two which have been stated for a second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs 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.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 03 October 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Prospect Private Nursing Home Ltd/Mr Thomas Mark McMullan	**Registered manager:** Mrs Elizabeth Jane Ross
Person in charge of the home at the time of inspection: Mrs Elizabeth Jane Ross	**Date manager registered:** 01 April 2005
Categories of care: NH-I, NH-PH	**Number of registered places:** 52

3.0 Methods/processes

- 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 we met with 25 patients, three registered nurses, six care staff, two activities therapists and one catering staff.

Six patients, six relatives and six staff questionnaires were left for distribution. Six patients, three staff and four relatives completed and returned questionnaires within the allocated timeframe.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- three patient care records
- staff training records
- accident and incident records
- notifiable events records
- complaints and compliments records
- sample of audits
- policy on meals and mealtimes

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 03 October 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and was validated at this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 03 October 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 15 (1) (e) **Stated:** First time	The registered provider must ensure the nursing home has been registered for the category of nursing appropriate to the patient's needs.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager, review of the certificate of registration and observation of the categories of care of the patients accommodated in the home evidenced that this requirement had been met.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 41.1 **Stated:** First time	The registered provider should review staffing levels/ deployment to ensure that, at all times, the staff on duty meets the assessed needs of patients.	**Met**
	Action taken as confirmed during the inspection: Review of three weeks duty rotas, discussion with staff, patients and relatives and observation of care practices evidenced that there was sufficient staff on duty to meet the assessed needs of patients. Refer to section 4.3.	
Recommendation 2 **Ref**: Standard 4.8 **Stated:** First time	The registered provider should submit timescales for the delivery of the stand aid hoist to ensure the risks to both patients and staff are minimised.	**Met**
	Action taken as confirmed during the inspection: A new stand aid hoist had been purchased and was operational at the time of the inspection.	

Recommendation 3 **Ref**: Standard 41 **Stated:** First time	The registered provider should ensure staff meetings take place for all grades of staff, on a regular basis and at a minimum quarterly. Minutes of meetings should be maintained.	**Partially Met**
	Action taken as confirmed during the inspection: There was evidence of a meeting with catering staff on 23 November 2016. Discussion with the registered manager confirmed that further meetings would be planned with other staff groups. The registered manager planned to delegate the management of staff meetings to the heads of department.	
Recommendation 4 **Ref**: Standard 35.6 **Stated:** First time	The registered provider should ensure that patients care records are audited on a monthly basis. The results of audits should be analysed and appropriate actions taken to address any shortfalls identified. There should be evidence that the necessary improvements have been embedded into practice.	**Partially Met**
	Action taken as confirmed during the inspection: There was evidence that care records had been audited on a monthly basis. Whilst an action plan was in place, there was no evidence of dates for completion of actions, or verification by the registered manager that actions had been completed. The registered manager agreed to further develop the audit template to include these details. This recommendation has been partially met and will be stated for the second time.	
Recommendation 5 **Ref**: Standard 32.1 **Stated:** Second time	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.	**Met**
	Action taken as confirmed during the inspection: Review of a sample of three patients care records evidenced that end of life care plans were in place and included identified religious, spiritual and cultural needs.	

Recommendation 6 **Ref**: Standard 4.1 **Stated:** Second time	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.	**Met**
	Action taken as confirmed during the inspection: Three patients care records were reviewed and evidenced that this recommendation had been met.	

4.3 Is care safe?

The registered 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. A review of the staffing rotas for the weeks commencing 27 February, 06 and 13 March 2017 evidenced that the planned staffing levels were adhered to.

Discussion with patients, relatives and staff evidenced that there were no concerns regarding staffing levels. One relative, who completed and returned a questionnaire following the inspection, indicated some concerns regarding staffing levels. Refer to section 4.5 for further details. This was discussed with the registered manager for follow up as appropriate.

Review of the training matrix/schedule for 2016/17 indicated that all staff had completed mandatory training to date. Additional training in the management of patients with swallowing difficulties had been provided in 2014. It is recommended that an update in this training is provided for all relevant staff. Staff consulted with and observation of care delivery and interactions with patients, clearly demonstrated that knowledge and skills gained through training and experience were embedded into practice.

A policy dated January 2009 was in place in respect of meals, mealtimes and nutrition. A system was in place to ensure all relevant staff had read and understood the policy. A recommendation has been made to ensure this policy is subject to a systematic three yearly review at a minimum (and more frequently if required) and the registered manager ratifies any revision to the policy.

Up to date nutritional guidelines were available and used by staff on a daily basis.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout.

Fire exits and corridors were observed to be clear of clutter and obstruction and equipment was appropriately stored.

Areas for improvement

Two recommendations have been made in respect of staff training and review of the policy on nutrition, meals and mealtimes.

Number of requirements	0	Number of recommendations	2

4.4 Is care effective?

Review of three patients' care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that care had been assessed, planned, evaluated and reviewed in accordance with NMC guidelines. Risk assessments informed the care planning process.

Care records reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such speech and language therapist (SALT) or dieticians.

Supplementary care charts such as repositioning and food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

All staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff confirmed that if they had any concerns, they could raise these with the registered manager. A recommendation has been stated for the second time in respect of staff meetings. Refer to section 4.2.

Patients and their representatives expressed their confidence in raising concerns with the home's staff/management.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Observation of the lunch time meal confirmed that patients were given a choice in regards to, food and fluid choices and the level of help and support requested. The majority of patients chose to come to the dining room where the tables were nicely presented with cutlery, crockery and a choice of condiments. Those patients who choose to remain in their bedroom were served their meals on trays set with condiments; the meals were covered prior to leaving the kitchen. A record was maintained for all patients to reflect their food and fluid intake at each mealtime. A discussion with catering staff demonstrated that they were knowledgeable regarding the patients dietary needs. This included; patients who required modified diets; diabetic diets and food fortification. The daily menu was displayed in the dining rooms and offered patients a choice of two meals for lunch and dinner. All the meals looked and smelt attractive and appealing and patients appeared to enjoy their lunch.

Where patients required assistance with meals, staff were observed to offer patients reassurance and assistance in a discreet, unhurried and sensitive manner.

Patients spoken with were complimentary regarding the care they received and life in the home. Those patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

As part of the inspection process, we issued questionnaires to staff, patients and patients' representatives. Three staff, four relatives and six patients completed and returned questionnaires within the required time frame. Some comments are detailed below.

Staff

- "I am very happy working here, I have no concerns"
- "I have been working here for many years and really like it. There is a very caring, family ethos"

Patients

- "staff are all good. They would kill you with kindness"
- "the food is very good"
- "I'm settling in well. I like it here"

Relatives

- "care assistants seem extremely busy at times and patients have to wait quite a long time to be taken to the toilet"
- "I am made to feel welcome when I visit"
- "the care is excellent. I have no concerns"

The comment made by the relative with regard to staffing was discussed with the registered manager for follow up.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were knowledgeable in regards to their roles and responsibilities.

The certificate of registration issued by RQIA was displayed in the home. Discussion with the registered manager, a review of care records and observations confirmed that the home was operating within its registered categories of care.

Review of the home's complaints records and discussion with the registered manager evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

There was evidence of monthly audits of care records. Whilst an action plan was in place, there was no evidence of dates for completion of actions, or verification by the registered manager that actions had been completed. A recommendation has been stated for the second time. Refer to section 4.2.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs 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 failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider 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 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements - None

Recommendations	
Recommendation 1 **Ref**: Standard 41 **Stated:** Second time **To be completed by:** 30 April 2017	The registered persons should ensure staff meetings take place for all grades of staff, on a regular basis and at a minimum quarterly. Minutes of meetings should be maintained. **Ref: Section 4.2** **Response by registered provider detailing the actions taken:** Meetings to take place April/May 2017 and quarterly thereafter.
Recommendation 2 **Ref**: Standard 35.6 **Stated:** Second time **To be completed by:** 30 April 2017	The registered persons should ensure that patients care records are audited on a monthly basis. The results of audits should be analysed and appropriate actions taken to address any shortfalls identified. There should be evidence that the necessary improvements have been embedded into practice. **Ref: Section 4.2** **Response by registered provider detailing the actions taken:** Audit tool developed further to analyse audit results and actions.
Recommendation 3 **Ref**: Standard 36.4 **Stated:** First time **To be completed by:** 30 April 2017	The registered persons should ensure the policy on nutrition, meals and mealtimes is subject to a systematic three yearly review at a minimum (and more frequently if required) and the registered manager ratifies any revision to the policy. **Ref: Section 4.3** **Response by registered provider detailing the actions taken:** Policy reviewed and updated.
Recommendation 4 **Ref**: Standard 12.9 **Stated:** First time **To be completed by:** 31 May 2017	The registered persons should ensure all relevant staff have been provided with update training in managing feeding techniques for patients who have swallowing difficulties. **Ref: Section 4.3** **Response by registered provider detailing the actions taken:** Training booked for 24th May 2017

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

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