The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Prospect**

Provider: **Prospect Private Nursing Home Ltd**

Date of Inspection: **11 August 2026**

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider:	Prospect Private Nursing Home Ltd
Responsible Individual/Responsible Person:	Mr Thomas Mark McMullan
Registered Manager:	Miss Sinead Kerr
Service Profile – Prospect is a nursing home registered to provide general nursing care for up to 53 patients over and under the age of 65 years of age. Patients have access to a range of communal rooms and outdoor spaces.	

2.0 Inspection summary

An unannounced inspection took place on 11 August 2026, between 8.50am and 4.30pm by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 18 February 2026 and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection found that safe, effective and compassionate care was delivered to patients and that the home was well led. Details and examples of the inspection findings can be found in the main body of the report.

It was evident that staff promoted the dignity and well-being of patients and that staff were knowledgeable and well trained to deliver safe and effective care. Patients said that living in the home was a good experience.

While we found care to be delivered in a safe and compassionate manner, improvements were required to ensure the effectiveness and oversight of the care delivery.

As a result of this inspection four areas for improvement were assessed as having been addressed by the provider. Other areas for improvement have either been stated again or will be reviewed at the next inspection.
Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patient's, relatives, staff or the commissioning trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards. Inspectors will also observe care delivery and may conduct a formal structured observation during the inspection.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Patients spoken with told us that they were happy and 'comfortable' living in the home. They told us that they had choice in how to spend their day and that there were a variety of activities available.

Some patients told us that there was not enough choice of meal options for their specialist diet. These comments were passed to the manager for their review.

Patients told us that the staff are kind and include them in their care. They said that staff took time to explain their care plan to them and encouraged them to engage with health care professionals, where appropriate e.g. speaking on the telephone to their GP.

Visitors/ relatives spoken with said that they were 'very pleased' with the care their relative received and that staff were friendly and communicated any changes with them promptly. They felt the home was clean and any small issues they might raise with regards to care or the environment are dealt with promptly by staff or management.

Discussion with patients confirmed that they were able to choose how they spent their day. For example, patients could spend their time in their room, the dayroom or go out with their family where appropriate.

Patients said that the home celebrates birthdays and special occasions, one resident spoken with had a birthday banner and balloons displayed for them and said they were 'looking forward to their cake'.

Patients told us that they were encouraged to participate in residents' meetings which provided an opportunity for them to comment on aspects of the running of the home. For example, planning of activities.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of patients. There was evidence of systems in place to manage staffing.

Patients said that there was enough staff on duty to help them. They said that staff responded to call bells promptly and did not feel rushed to get up in the morning.
Staff said there was good team work and that they felt well supported in their role and that they were satisfied with the staffing levels.
Staff responded to requests for assistance promptly in a caring and compassionate manner.

It was noted that whilst there has been improvement in recruitment practices since last inspection, not all required checks were completed prior to staff commencing employment in the home. This was discussed with the manager and an area for improvement has been stated for the second time.

There is a system in place to manage the registration of nurses and care staff.

3.3.2 Quality of Life and Care Delivery

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable of individual patients' needs, their daily routine wishes and preferences.

Staff were prompt in recognising patients' needs and any early signs of distress or illness, including those patients who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs.

Staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner, and by offering personal care to patients discreetly. Staff were also observed offering patient choice in how and where they spent their day or how they wanted to engage socially with others.

At times some patients may require the use of equipment that could be considered restrictive or they may live in a unit that is secure to keep them safe. It was established that safe systems were in place to safeguard patients and to manage this aspect of care.
Patients may require special attention to their skin care. These patients were assisted by staff to change their position regularly and care records reflected the patients' assessed needs.

Where a patient was at risk of falling, measures to reduce this risk were put in place. For example, alarm mats were in place or enhanced supervision.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this may include simple encouragement through to full assistance from staff and their diet modified.

The dining experience was an opportunity for patients to socialise, music was playing, and the atmosphere was calm and unhurried. It was observed that patients were enjoying their meal and their dining experience. Prior to the mealtime staff held a safety pause to consider those patients who required a modified diet. It was observed that staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed. It was noted that whilst a menu board was in place, it was not completed to reflect the meals on offer that day. An area for improvement has been identified.

The importance of engaging with patients was well understood by the manager and staff. Whilst there was a comprehensive fortnightly schedule of activities in place, there were no planned activities on the day of inspection. Patients were observed to be reading the daily newspaper, knitting, spending time with visitors or watching television.

Life story work with patients and their families helped to increase staff knowledge of their patients' interests and enabled staff to engage in a more meaningful way with their patients throughout the day.

Arrangements were in place to meet patients' social, religious and spiritual needs within the home.

The fortnightly programme of social events was displayed on the noticeboards and in the patient bedrooms, advising of future events.

Patients' needs were met through a range of individual and group activities such as smoothie making, cookery demonstrations, board games, arts and crafts, live music, chair exercises or movie nights.

Activities for patients were provided which involved both group and one to one activity. Birthdays and annual holidays were celebrated and on occasion patients, families and staff attended larger events such as BBQs or church services.

3.3.3 Management of Care Records

Patients' needs were assessed by a nurse at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals.

Review of a sample of patient care plans and patient records evidenced that nursing staff did not always ensure that they reflected the patients' current assessed care needs and diagnosis. Details were discussed with the manager and an area for improvement was identified. Supplementary records were not completed accurately and did not reflect the assessed need of the patient. An area for improvement has been stated for a second time.

Patients care records were held confidentially.

3.3.4 Quality and Management of Patients' Environment

The home was clean, tidy and well maintained. For example, patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were homely, well decorated, suitably furnished, warm and comfortable.

Review of records confirmed that environmental and safety checks were carried out, as required on a regular basis, to ensure the home's was safe to live in, work in and visit. For example, fire safety checks, nurse call system checks, electrical installation checks and water temperature checks.

There was evidence that systems and processes were in place to manage infection prevention and control which included policies and procedures and regular monitoring of the environment and staff practice to ensure compliance.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Kerr has been the manager in this home since 24 January 2026.

Patients, relatives and staff commented positively about the manager and described them as approachable, supportive and able to provide guidance.

Review of a sample of records evidenced that a system for reviewing the quality of care, other services and staff practices was in place. There was evidence that the manager responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and/or the quality of services provided by the home.

It was identified that not all notifiable events occurring within the home were reported to the RQIA, in accordance with regulatory requirements. An area for improvement was identified.

Patients and their relatives said that they knew who to approach if they had a concern and had confidence that any complaint would be managed well.

A register of compliments was maintained by the home and comments from patients and relatives were positive and they expressed gratitude for the high standard of care of their relative.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	3*	3*

* the total number of areas for improvement includes two that have been stated for a second time and one which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Sinead Kerr, Registered Manager and Mr Thomas Mark McMullan, Responsible Individual, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 21 (1) (b) Schedule 2 **Stated:** Second time	The registered person shall ensure that all pre-employment checks are completed before any staff commence working in the home and evidence retained of managerial oversight of all such records. Ref: 3.3.1
To be completed by: 18 February 2026	**Response by registered person detailing the actions taken:** A full review of recruitment and personnel files has been undertaken to ensure all pre-employment checks are completed and documented before any staff member commences employment within the home. A recruitment checklist has been implemented to provide a clear record of all required checks including identity verification, employment history, nursing qualification,right to work and immigration status where applicable. Management will verify and sign the checklist prior to the staff member commencing employment. An audit of personnel files will be undertaken for the next 3 months and thereafter as part of the home's quality assurance programme. any identified gaps will be addressed immediately with evidence of managerial oversight.
Area for improvement 2 **Ref:** Regulation 16 **Stated:** First time **To be completed by:** 11 August 2026	The Registered Person shall ensure that all nursing care plans reflect the assessed need for the patient, are patient centred and reviewed in a timely manner so they accurately reflect care required. Ref: 3.3.3
	Response by registered person detailing the actions taken: A comprehensive review of residents' care plans has been undertaken to ensure care documentation reflects each person's assessed needs, is indiviualised and person centred.Care plans have been reviewed against current assessments and risk assessments with amendments made where required to ensure the information provides clear guidance to staff regarding the resident's care needs. Staff have been reminded of their responsibility to report any changes in an individual's care so that assessments and care plan can be updated without delay. Management will undertake regular audits of care plans to monitor compliance including checking care plan is relevant to resident's needs, person centred and consistent with assessments,risk assessments and the care being delivered.

Area for improvement 3 **Ref:** Regulation 30 **Stated:** First time **To be completed by:** 11 August 2026	The registered person shall ensure that notifiable events are reported to the RQIA in a timely manner. Ref: 3.3.5
	Response by registered person detailing the actions taken: Management have reviewed the home's procedure for identifying, recording and reporting notifiable events to RQIA. Staff have been reminded of their responsibility to immediately report incidents/events to management so that circumstances can be assessed and the appropriate notification submitted within the required timescale.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 18 **Stated:** First time **To be completed by:** 10 September 2024	The registered person shall ensure that care records for the management of distressed reactions include patient-specific information to direct the use of prescribed medicines and that records of administration include the reason for and outcome of each administration. Ref: 2.0
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 2 **Ref**: Standard 4.9 **Stated:** Second time **To be completed by:** 18 February 2026	The registered person shall ensure supplementary care records in the home such as bedrail checks, repositioning and skin check charts are completed in full and include the time of such checks. These should be completed contemporaneously in keeping with the patients' assessed need. Ref: 3.3.2
	Response by registered person detailing the actions taken: Management has reviewed the arrangements for the completion of supplementary care records. Staff have been reminded of the requirement to complete all relevant records contemporaneously and in full including recording specific time the check was undertaken, nurses will have daily oversight of supplementary documentation any descrepancies or omissions will be addressed promptly with staff member concerned through supervision, additional training or other appropriate management action.Management will undertake regular audits of supplementary documentation to ensure they are completed accurately, timed appropriately and demonstrate the care required. The findings of these audits will be reviewed as part of the home's quality assurance process.

Area for improvement 3 **Ref:** Standard 12 (6) **Stated:** First time **To be completed by:** 11 August 2026	The registered person shall ensure that the daily menu is displayed in a suitable format for all patients at each meal time. Ref: 3.3.2
	Response by registered person detailing the actions taken: Arrangements for displaying the daily menu have been reviewed . The menu is now clearly displayed for resident's. Kitchen staff have been reminded to ensure that the menu is displayed daily and accurately reflects the meals being offered, any variations or changes to the menu are updated promptly. Management will monitor compliance through regular daily checks and quality assurance audits to ensure the menu remains visible, current and accessible to all residents.

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

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