The Regulation and Quality Improvement Authority

Inspection Report

28 October 2021

Burleigh Hill House Residential Home

Type of service: Residential Care Home
Address: 79 North Road,
Carrickfergus, BT38 7QZ
Telephone number: 028 9336 5652

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: MD Healthcare Ltd. **Responsible Individual:** Mrs Lesley Catherine Megarity	**Registered Manager:** Mrs Emeliza Insauriga **Date registered:** 23 January 2020
Person in charge at the time of inspection: Mrs Emeliza Insauriga – Rgistered Manager	**Number of registered places:** 21 The total number of registered beds will increase to 23 once an identified nursing patient is no longer accommodated in room 44. Category RC-A for 1 identified resident only.
Categories of care: Residential Care (RC) I – Old age not falling within any other category. MP – Mental disorder excluding learning disability or dementia. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years. PH(E) - Physical disability other than sensory impairment – over 65 years. A – Past or present alcohol dependence.	**Number of residents accommodated in the residential care home on the day of this inspection:** 19
Brief description of the accommodation/how the service operates: This home is a registered Residential Care Home which provides health and social care for up to 21 residents. Residents' bedrooms are located on the first floor. Residents have access to a communal dining room on the ground floor and communal lounges on both floors. The home is located within a Nursing Home and the Registered Manager for this home manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 28 October 2021 from 9.05 am to 7.00 pm. The inspection was carried out by a care inspector. The Nursing Home was also inspected on the same day.

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

Residents spoke positively about living in the home and they were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Staff were seen to provide care in a compassionate manner and to promote the dignity and well-being of residents.

Areas requiring improvement identified are discussed in the main body of the report.

RQIA were assured that the delivery of care and service provided in Burleigh Hill House Residential Home was safe, effective, compassionate and that the home was well led. Addressing the areas for improvement will further enhance the quality of care and services provided.

The findings of this report will provide the manager with the necessary information to improve staff practice and the residents' experience.

3.0 How we inspect

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

In preparation for this inspection, a range of information about the service was reviewed to help us plan the inspection.

Throughout the inspection RQIA will seek to speak with residents, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires and 'Tell Us' cards were provided to give residents and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The daily life within the home and how staff went about their work was observed.

A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with Emeliza Insauriga, Registered Manager, at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we spoke with 10 residents and four staff.

Residents said that felt well looked after and that staff were helpful and friendly.

Staff said that they enjoyed working in the home, communication was good and they felt well supported by the manager.

A record of compliments and thank you cards received about the home was kept and shared with the staff team, this is good practice.

Comments made by residents and staff were brought to the attention of the manager for information and action if required.

No completed questionnaires were returned within the indicated timeframe and no staff responded via the online survey.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 23 November 2020		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 30 **Stated:** First time	The registered person shall ensure that RQIA is informed of all notifiable accidents/incidents appropriately.	**Met**
	Action taken as confirmed during the inspection: Review of records confirmed that this area for improvement had been met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

The staff duty rota accurately reflected the staff working in the home on a daily basis. The duty rota identified the person in charge when the manager was not on duty. It was noted that if a shift was worked by bank staff this not always clearly indicated. This was discussed with the manager who agreed that going forward the duty rota will clearly reflect if a shift is worked by bank staff.

Review of records provided assurances that all relevant staff were registered with the Nursing and Midwifery Council (NMC) or the Northern Ireland Social Care Council (NISCC) and that these registrations were effectively monitored on a monthly basis.

There were systems in place to ensure staff were trained and supported to do their job. An overview of staff compliance with mandatory training was maintained and staff were reminded when training as due. Review of records showed that mandatory training comprised of a range of relevant topics, for example, adult safeguarding and infection prevention and control. The majority of courses were provided online and courses with practical elements were delivered face to face, for example, moving and handling and fire safety. Staff said that they felt adequately trained to carry out their roles and responsibilities within the home.

Staff said that teamwork was good and that there was enough staff on duty to meet the needs of the residents. The manager told us that the number of staff on duty was reviewed on at least a monthly basis to ensure the needs of the residents were met.

A record of staff meetings was maintained although these involved both the residential and nursing home; this was discussed with the manager who said that separate meetings and records will be maintained going forward.

It was noted that there was enough staff in the home to respond to the needs of the residents in a timely way.

Residents said that there were enough staff to help them and that they felt well looked after.

5.2.2 Care Delivery and Record Keeping

Staff said they met for a handover at the beginning of each shift to discuss any changes in the needs of the residents. Staff demonstrated their knowledge of individual residents' needs, preferred daily routines, likes and dislikes. Staff were seen to be skilled in communicating with the residents and to treat them with respect and understanding.

Where a resident was at risk of falling measures to reduce this risk were put in place, for example, equipment such as alarm mats were in use where required. Those residents who were at risk from falls had relevant care plans in place. Review of records confirmed that in the event of a fall or an accident staff took appropriate action. A monthly falls/accident analysis is carried out to establish if there are any patterns or trends and to determine if there are other measures that can be put in place to reduce the risk of a recurrence.

Equipment such as alarm mats can be considered to be restrictive. It was established that safe systems were in place to manage this aspect of care. A monthly analysis of restrictive practices is undertaken.

Residents who are less able to mobilise were assisted by staff to mobilise or change their position regularly. Care records accurately reflected the residents' needs and included recommendations from the Physiotherapist and Occupational Therapist (OT) if required. Staff said that when necessary they consulted other members of the multi-disciplinary team, for example, the District Nurse, and followed the recommendations they made.

Good nutrition and a positive dining experience are important to the health and social wellbeing of residents. Residents may need a range of support with meals from simple encouragement through to full assistance and staff were seen to assist residents appropriately. The dining experience was seen to be calm, relaxed and unhurried. Residents were offered a choice of meals; the food was attractively presented and looked appetising. Staff told us how they were made aware of residents' nutritional needs to ensure they were provided with the right consistency of diet.

The recommendations of the Dietician and the Speech and Language Therapist (SALT) were clearly recorded in the care plans reviewed. However, we observed that the recommended consistency of diet and fluids was not always recorded in the residents' food and fluid intake booklets. An area for improvement was identified.

It was observed that identified food intake records were completed prior to lunch finishing; staff should not assume how much a resident will eat. Where records of food and intake are required these should be kept up to date, contemporaneous and accurate. An area for improvement was identified.

Review of the record of fluid intake for residents identified that no fluid intake was generally recorded by night duty staff. An area for improvement was identified.

Issues identified regarding food and fluid records were brought to the attention of the manager for information and action. Following the inspection the manager offered RQIA assurances that staff had been reminded of the importance of accurate recording and that residents were offered fluids appropriately but that night staff had omitted to accurately record this. The manager said that record keeping regarding food and fluid intake would be closely monitored going forward.

Residents said that they enjoyed the food provided in the home and did not raise any concerns about provision of drinks. It was observed that drinks, meals and snacks were offered regularly and that jugs of juice were provided in residents' bedrooms.

There was evidence that residents' weights were checked at least monthly to monitor weight loss or gain. An audit of residents' weights was completed to determine if any actions were required.

It was observed that staff respected residents' privacy and dignity; they knocked on bedroom and bathroom doors before entering and discreetly assisted residents with their personal care needs.

Residents' needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet residents' needs and these included any advice or recommendations made by other healthcare professionals. Residents care records were held confidentially.

Care records were regularly reviewed and updated to ensure they continued to meet the residents' needs. Residents, where possible, were involved in planning their own care and the details of care plans were shared with residents' relatives, if this was appropriate.

Residents' individual likes and preferences were reflected throughout the records. The care plans were detailed and contained specific information on each residents' care needs and what or who was important to them. Care plans reviewed included information regarding, for example, preferred time to get up and go to bed, dietary likes and dislikes, preference for where to eat meals and favourite activities.

Informative and person centred daily records were kept of how each resident spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded.

Residents said that they felt well looked after and that staff were helpful and friendly.

5.2.3 Management of the Environment and Infection Prevention and Control

Observation of the environment evidenced that the home was warm, clean, tidy and well maintained. The home was in good decorative order. Residents' bedrooms were attractively decorated and personalised with items that were important to them, for example, family photographs, ornaments, pictures and plants.

Corridors and fire exits were clear of clutter and obstruction. The home's current fire risk assessment included evidence that action had been taken to address required improvements. A record of fire drills was maintained.

There was evidence that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. For example, the home participated in the regional testing arrangements for residents, staff and care partners and any outbreak of infection was reported to the Public Health Authority (PHA).

Review of records, observation of practice and discussion with staff confirmed that effective training on infection prevention and control (IPC) measures and the use of PPE had been provided.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept.

Residents said that the home was kept clean and tidy.

5.2.4 Quality of Life for Residents

Discussion with residents confirmed that they were able to choose how they spent their day. It was observed that staff offered residents choices regarding, for example, where to eat their meals and if they wanted to take part in planned activities. It was obvious that staff knew the residents well and they were seen to speak to them in a warm, friendly and caring manner.

Residents were provided with an opportunity to comment on aspects of the running of the home, for example, food questionnaires had recently been completed. The manager said that the cook was provided with feedback on the resident's opinions, suggestions and requests and this information would help with menu planning.

Residents told us that staff listened to them, offered choices throughout the day and helped sort out any concerns they might have. One resident said that they had a small appetite and that staff always gave them smaller portions at mealtimes; they said it was good staff remembered this. Another resident remarked that "if staff can help, they will".

Staff discussed the importance of letting residents choose how to spend their day and supporting them to do what they preferred, for example, joining in activities, getting ready for visits from relatives and choosing whereabouts to spend their time.

There was a range of activities provided for residents by activity staff, for example, quizzes, art class, games, 'knit and natter', armchair aerobics and sing-a-longs. The activity coordinator said that all residents were welcome to join in but that one to one activities were also available if residents preferred. The activity coordinator said that in order to help plan a suitable and inclusive activity schedule they spoke to the residents and their families to get an idea of interests, hobbies and background. The activity coordinator said that residents especially enjoyed art classes, memory activities and reminiscence.

Residents were observed taking part in an art class during the inspection and they were clearly enjoying this very much. The activity coordinator took residents' differing abilities into account and was seen to be very helpful and encouraging.

In addition to the activity schedule residents were offered an opportunity to attend church services and parties were organised for birthdays and special events such as Hallowe'en.

Staff recognised the importance of maintaining good communication with families, especially whilst visiting was disrupted due to the COVID-19 pandemic. Staff assisted residents to make phone or video calls. Visiting and care partner arrangements were in place as per the current guidance. The home has a visiting champion on duty every day. The visiting champion said that their role involves taking bookings for visits and assisting visitors with their PPE and hand hygiene requirements. The visiting champion said the role was very enjoyable and rewarding and they could see the positive benefits for the residents.

The atmosphere in the home was friendly and pleasant and staff were seen to be attentive to the residents and to answer requests for assistance promptly.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection. Mrs Emeliza Insauriga has been the Registered Manager in this home since 23 January 2020. Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about residents, care practices or the environment.

There was evidence that a robust system of auditing was in place to monitor the quality of care and other services provided to residents. There was evidence of auditing across various aspects of care and services provided by the home. It was observed that the IPC audit and housekeeping audit related to both the residential and the nursing home; this was discussed with the manager who said that going forward separate audits would be completed.

Review of the home's record of complaints confirmed that there was a system in place to manage these. The manager said that the outcome of complaints was used as a learning opportunity to improve practices and/or the quality of services provided by the home.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. The group's Deputy Chief Executive was identified as the appointed safeguarding champion for the home. It was established that systems and processes were in place to manage the safeguarding and protection of vulnerable adults.

A review of the records of accidents and incidents which had occurred in the home found that these were managed correctly and reported appropriately.

The home was visited each month by a representative of the registered provider to consult with residents, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. These are available for review by residents, their representatives, the Trust and RQIA.

Staff said that they felt supported, the manager was approachable and they enjoyed working in the home.

6.0 Conclusion

Residents looked well cared for and were seen to be comfortable, content and settled in the home and in their interactions with staff.

The home was clean, tidy, warm and welcoming.

Staff spoke positively about working in the home and did not express any concerns about the service.

Based on the inspection findings three areas for improvement were identified regarding food and fluid intake record keeping.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005 and the Residential Care Homes' Minimum Standards (August 2011) (Version 1:1)

	Regulations	Standards
Total number of Areas for Improvement	1	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Emeliza Insauriga, Registered Manager, 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 Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 19 (3)(a) **Stated:** First time **To be completed by:** Ongoing from the date of the inspection.	The registered person shall ensure that food intake records are kept up to date and completed accurately and contemporaneously. Ref: 5.2.2
	Response by registered person detailing the actions taken: Supervision sessions were held with staff regarding the importance of ensuring food intake records are kept up to date and completed accurately and contemporaneously. This will be monitored by the Home Manager through the auditing process
Action required to ensure compliance with the Residential Care Homes Minimum Standards (August 2011) (Version 1:1)	
Area for improvement 1 **Ref:** Standard 8.5 **Stated:** First time **To be completed by:** Ongoing from the date of the inspection.	The registered person shall ensure that the recommended consistency of diet and fluids is recorded on the residents' food and fluid intake booklets. Ref: 5.2.2
	Response by registered person detailing the actions taken: This was actioned immediately following the Care Inspection, all records now have the recommended consistency of diet and fluids recorded on each resident's food and fluid intake booklets. The Home Manager will continue to monitor this through the auditing process

<table>
<tr><td rowspan="2">Area for improvement 2

Ref: Standard 8.5

Stated: First time

To be completed by:
Ongoing from the date of the inspection.</td><td>The registered person shall ensure that night duty staff accurately and contemporaneously record residents’ fluid intake.

Ref: 5.2.2</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Supervision sessions have been carried out with staff to highlight the importance of recording accurately and contemporaneously all resident fluid intake. The Home Manager will monitor this through the auditing process</td></tr>
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