Unannounced Care Inspection Report
26 April 2016

Burleigh Hill House

Address: 79 North Road, Carrickfergus BT38 7QZ
Tel No: 028 9336 5652
Inspector: Heather Sleator

1.0 Summary

An unannounced inspection of Burleigh Hill House took place on 26 April 2016 from 09:45 to 16:35 hours.

The inspection sought to assess progress with issues raised during and since the previous inspection and to determine if Burleigh Hill House was delivering safe, effective and compassionate care and if the service was well led. The inspection also incorporated a post registration inspection due to a change of ownership from 1 April 2016. MD Healthcare Ltd is now the registered organisation and Mrs Lesley Megarity, the registered person.

Is care safe?
Following discussion with patients, representatives and staff; and a review of records there was evidence of good delivery of care and positive outcomes for patients. The registered person, Mrs Megarity plans to refurbish and enhance the environment of the home, both internally and externally.

Is care effective?
There was evidence of positive outcomes for patients through the competent delivery of safe and effective care. Recommendation have been made that the home establishes a system to seek the views of patients regarding the services provided by the home and the safe storage of records.

Is care compassionate?
There was evidence of good communication in the home between staff and patients and patients and their representatives were very praiseworthy of staff.

Is the service well led?
There was evidence that effective management systems had been established in the home and that the services provided by the home were regularly monitored. One recommendation has been stated in relation to quality auditing of the services provided by the home.

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 Department of Health (DOH) Care Standards for Nursing Homes 2015.

For the purposes of this report, the term 'patients' will be used to described those living in Burleigh Hill House which provides both nursing and residential care.

1.1 Inspection outcome

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

Details of the QIP within this report were discussed with Josue Notarte, Deputy Manager and J P Watson, Deputy Chief Executive MD Healthcare Ltd, as part of the inspection process. The timescales for completion commence from the date of inspection.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection on 14 March 2016. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

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

2.0 Service details

Registered organisation/registered person: MD Healthcare Lesley Megarity	**Registered manager:** Emeliza Insauriga acting home manager
Person in charge of the home at the time of inspection: Josue Notarte, deputy manager	**Date manager registered:** Acting home manager – not registered
Categories of care: RC-A, NH-I, NH-PH, RC-I, NH-LD, RC-MP(E), RC-PH(E)	**Number of registered places:** 56

3.0 Methods/processes

Prior to inspection we analysed the following:

- notifiable events 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 plan (QIP) from the previous care inspection
- the previous care inspection report

During the inspection the inspector met with approximately 15 patients both individually and in groups, two registered nurses, four care staff, housekeeping staff, catering staff, activities coordinators and two patients visitors/representative.

The following information was examined during the inspection:

- three patient care records
- staff roster
- staff training records
- complaints and compliments records
- incident and accident records
- records of audits

- records of meetings
- records of the monitoring visits
- supplementary nursing records

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent care inspection dated 14 March 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. Validation of compliance of this QIP was undertaken as part of this inspection process. Details recorded below.

4.2 Review of requirements and recommendations from the last care inspection dated 14 March 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 21 **Stated:** First time	The registered persons shall ensure that that prior to any staff commencing employment in the home that the employment file is thoroughly checked by the registered persons to ensure they are fully satisfied that all information has been received and that they are satisfied that they can commence employment. Completed personnel files should be verified as complete signed by the registered persons.	**Met**
	Action taken as confirmed during the inspection: The recruitment and selection records of the two most recently employed staff were viewed. Evidence was present that information in accordance with regulation 21, schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005 and Department of Health (DHSSPS) Care Standards for Nursing Homes 2015	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 21 **Stated:** First time	The registered persons should make suitable arrangements to ensure that there is sufficient discussion with district nursing staff and that care records are updated regarding the care delivered to patients in the home by any healthcare professional following their visit.	**Met**

	Action taken as confirmed during the inspection: Discussion with the deputy manager and staff confirmed that nursing and care staff were updated regarding the care and treatment afforded to patients by other healthcare professionals.	

4.3 Is care safe?

The deputy 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 roster for weeks commencing 19 and 25 April 2016 evidenced that the planned staffing levels were adhered to. In addition to nursing and care staff staffing rosters it was confirmed that administrative, maintenance, catering, domestic and laundry staff were on duty daily. Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. Staff also stated that staffing levels were sufficient as long as the full complement of staff rostered to work were present, as short notice staff sickness placed an 'extra burden' on staff, refer to section 4.5 for further comment. Relatives commented positively regarding the staff and care delivery.

A review of two personnel files evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. Discussion with the administrator and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff were appropriately managed.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Two completed induction programmes were reviewed. The programmes included a written record of the areas completed and the signature of the person supporting the new employee. On completion of the induction programme, the employee and the inductor signed the record to confirm completion and to declare understanding and competence. The registered manager also signed the record to confirm that the induction process had been satisfactorily completed.

Review of six records confirmed that a competency and capability assessment was completed with all registered nurses who were given the responsibility of being in charge of the home. However, three of the six competency assessments viewed had not been dated at the time of completion. Assurances were given by the Deputy Chief Executive, J P Watson that in future; all documentation would be signed and dated at the time of completion.

Training was available via an e learning system, internal face to face training arranged by management and training provided by the local health and social care trust. The review of staff training records evidenced that the registered manager had systems in place to monitor staff attendance and compliance with training. Discussion with the deputy manager, staff on duty and a review of records confirmed that there are systems in place to ensure that staff received regular supervision and an annual appraisal.

The deputy manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. Training records reflected that 90% of staff had undertaken safeguarding training in the past 12 months. Annual refresher training was considered mandatory by the home. A review of documentation confirmed that any

safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately. The acting home manager had robust systems in place to monitor the progress of safeguarding issues with the local health and social care trust.

Discussion with the deputy manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to the relevant bodies. A random selection of accidents and incidents recorded since the previous inspection evidenced that accidents and incidents had been appropriately notified to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. The acting home manager completed a monthly analysis accident, incidents and of falls to identify any trends or patterns.

An inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. The home was fresh-smelling, clean and appropriately heated. Ownership of the home transferred to MD Healthcare Ltd on 1 April 2016. The registered person, Mrs Lesley Megarity had informed RQIA of proposals to refurbish the environment of the home both internally and externally. This was timely as some aspects of the environment evidenced wear and tear and/or were outdated, for example; the home would benefit from redecoration, some bathrooms require upgrading, storage is limited as wheelchairs were being stored in a downstairs shower room and a further bathroom upstairs was being used solely for storage. This was discussed with Mr Watson and a recommendation is stated that a programme for improvements to the environment of the home, including the exterior, is submitted to RQIA.

Fire exits and corridors were observed to be clear of clutter and obstruction.

There were no issues identified with infection prevention and control practice.

Areas for improvement

It is recommended stated that a programme for improvements to the environment of the home, including the exterior, is submitted to RQIA.

Number of requirements		**Number of recommendations**:	**1**

4.4 Is care effective?

A review of three patient care records evidenced that initial plans of care were based on the pre admission assessment and referral information. As previously discussed a range of validated risk assessments were completed as part of the admission process.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians and palliative care nurse facilitators. Care records were regularly reviewed and updated, as required, in response to patient need. There was also evidence that staff were updated regarding the care and treatment afforded to the residential clients in the home, by the Community Nursing Service.

Staff demonstrated an awareness of the importance of contemporaneous record keeping. A recommendation is stated regarding the patient confidentiality and the storage of records and patient information. Supplementary care records for example; repositioning charts and food and fluid intake charts were observed on the corridor handrails outside of a number of patients' bedrooms and in the downstairs lounge. A more suitable arrangement for the storage of these records should be established.

It was observed that Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) directives were recorded in keeping with the Resuscitation Council (UK) guidelines and evidenced regular review by registered nursing staff and an annual review by the patient's general practitioner.

There was no evidence within the computerised care records that patients and/or their representatives were involved in the care planning process. Evidence was present of the regular and ongoing communication with relatives written within patient progress (daily) records. This was discussed with the deputy manager and it was agreed that a system would be put in place to evidence consultation with patients and/or their representatives in respect of care planning. Registered nurses spoken with confirmed that care management reviews were arranged by the relevant health and social care trust. These reviews were held annually but could be requested at any time by the patient, their family or the home.

Discussion with the deputy manager and staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication. Staff spoken with confirmed that the shift handover provided the necessary information regarding any changes in patients' condition. Staff meetings were held regularly and that records of these meeting were maintained. A review of records evidenced that the signatures of the staff attending were present. A detailed verbatim account of the meetings was present and due to this it was difficult to identify the decisions taken. Consideration should be given to reviewing the record of meetings template so as to provide clarity of the decisions taken to those staff unable to attend. The Chief Executive of MD Healthcare Ltd, Mrs Megarity, chaired the staff meeting of 11 April 2016 and this meeting was attended by 39 staff. A relatives meeting is being planned for the near future.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Staff also confirmed that if they had any concerns, they would raise these with the manager.

We discussed how the deputy manager consulted with patients and relatives and involved them in the issues which affected them. The most recent relatives meeting was the 1 March 2016. The minutes of this meeting and of the relatives meeting of 6 July 2015 were reviewed and confirmed who attended and the detail of the issues discussed. We were unable to confirm that patients meeting were held. It is recommended that a system is established to seek the views of patients regarding the services provided by the home.

A notice board displaying information for relatives was provided on each floor of the home. Information displayed included the Statement of Purpose, Patient Guide; how to make a complaint, the activities programme and information that the Regulation 29 monthly monitoring report was available in the home should relatives wish to read it.

The serving of lunch was observed. Tables were set with cutlery, condiments and napkins. Those patients who had their lunch in the lounge or bedroom were served their meal on a tray which was set with cutlery and condiments and the food was covered prior to leaving the dining room. Patients were enabled to choose which dish they preferred at the point of service. This was good practice.

The serving of the lunch was observed to be well organised with all of the patients being attended to in a timely manner. The meals were nicely presented and smelt appetising. All of the patients spoken with enjoyed their lunch.

Areas for improvement

It is recommended that any record which details patient information is stored safely.

It is recommended that a system is established to seek the views of patients regarding the services provided by the home.

Number of requirements		**Number of recommendations**:	**2**

4.5 Is care compassionate?

Observations throughout the inspection evidenced that there was a calm atmosphere in the home and staff were quietly attending to the patients' needs.

Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. We observed numerous occasions when staff offered patients' choice and took time to find out what the patients wanted when it was not always apparent and patients were unable to express their wishes clearly. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time. Staff spoken with were knowledgeable regarding patients likes and dislikes and individual preferences.

The activities coordinators developed a weekly programme of activities which was greatly enjoyed by patients. At the time of the inspection one of the coordinators was accompanying a patient into town as the patient wished to go shopping.

Patients spoken with commented positively in regard to the care they received. Those patients who were unable to verbally express their views were observed to be appropriately dressed and were relaxed and comfortable in their surroundings. Observation of care delivery confirmed that patients were assisted appropriately, with dignity and respect, and in a timely manner. As previously stated in section 4.4 it is recommended that a system is established to evidence that patients are consulted in respect of the quality of services provided by the home.

Numerous compliments had been received by the home from relatives and friends of former patients. A compliments folder was displayed in the entrance foyer of the home.

The following are some comments we received from patients:
'It's very good here, I was worried before I came but it's good.'
'Only good things to say about here.'
'Staff try their best.'
'Staff come around and ask you what you would like to eat.'

'The food is really, really good.'
'Staff are okay, wouldn't say they come too quickly when I press the bell.'

We met with two relatives during the inspection who stated:
'Staff and (patient) care is excellent.'
'I'm more than happy with (my relative's) care.'
'I can't speak highly enough of the staff.'

Questionnaires

As part of the inspection process we issued questionnaires to staff (10), patients (10) and patients' representatives (8). The returned questionnaires were positive regarding the quality of nursing and other services provided by the home. Specific comments are detailed below:

The following comments were provided by patients:
'I think the home could do with one or two more care staff.'
'As new management have taken over recently I have yet to meet the new boss.'

The following comments were provided by patients representatives:
'As there has been a change of ownership from 1 April 2016, it is not possible to comment on the new management of Burleigh Hill House.'
'Staff would have enough time to care if staff all turn up, sickness at the last minute is a problem especially at the weekends, it causes the others to be under pressure which isn't fair.'
'I have been here for over (number of) years with my relative every day and I am treated like one of the family. They are a great team, we have laughed and cried together and I would do anything to protect them and the home. I have never heard a raised voice or anything that would concern me. The home is the best.'

The following comments were provided by staff:
'Sometimes short staffed, not enough staff as staff always phoning in sick.'
'Staff don't get enough time with service users because staff have so much to do.'

Patients, their representative and staff have commented on staff shortages, especially at weekends. The acting manager is advised to review and continue to monitor the home's staffing arrangements, in conjunction with the comments and address the issues, where applicable.

Areas for improvement

No areas for improvement were identified in the assessment of compassionate care during the inspection.

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

4.6 Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home. An issue arose in relation to the registration categories of the home. This was discussed with the deputy manager and Mr Watson and it was agreed the issue would be discussed with the Trust and RQIA would be

informed of the outcome. Confirmation was received from the acting home manager, Emeliza Insauriga, on 10 May 2016 that the Trust had been notified and the issue would be addressed.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered. The Statement of Purpose and Patient Guide were displayed and available in each unit. Documentation/information displayed still referred to the home's previous name. Mr Watson confirmed this documentation would be amended as soon as possible.

Staff spoken with were knowledgeable regarding the new line management within the home and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. Discussions with staff also confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Patients and representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients and their representatives confirmed that they were confident that staff and /or management would address any concern raised by them appropriately. Patients were aware of who the acting home manager was. As previously discussed in section 4.5, information on how to make a complaint was displayed in the home.

A record of complaints was maintained by the acting home manager. The record included the date the complaint was received, the nature of the complaint, details of the investigation and a copy of the letter sent to the complainant. Discussion with the deputy manager and review of the home's complaints record 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.

A system was in place to monitor the quality of the services delivered. The acting home manager completed a programme of audits on a monthly basis. Areas for audit included care records, infection prevention and control practices, falls, complaints and the environment. The audits in relation to the kitchen/catering, domestic/estates and the audit of care records did not evidence that where an area for improvement was identified that an action plan was developed, completed and the area re-audited to check that the required improvement has been completed. A recommendation is stated.

Discussion with the deputy manager and review of records evidenced that the monthly monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005 and DHSSPS Care Standards for Nursing Homes 2015. During discussion with Mr Watson at the conclusion of the inspection, it was agreed the recording template for the monthly monitoring report would be revised and streamlined and for example, reflect the template available on RQIA's website, www.rqia.org.uk. Copies of the monitoring reports were available for patients, their representatives, staff and trust representatives. An action plan was generated following each monitoring audit to address any areas for improvement. Discussion with the deputy manager and a review of relevant records evidenced that all areas identified in the action plans had been addressed.

Areas for improvement

It is recommended that where an area for improvement was identified during audit an action plan will be developed, completed and the area re-audited to check that the required improvement has been completed

Number of requirements	0	Number of recommendations:	1

5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Josue Notarte, deputy manager and Mr JP Watson, deputy chief executive, 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 nursing home. 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.

5.1 Statutory requirements

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

5.2 Recommendations

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

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the acting home 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 by the acting home manager. 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 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 person/manager 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 person/manager with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref:** Standard 35.6 **Stated:** First time **To be completed by:** 30 June 2016	The registered person should ensure that the programme for the proposed works to the home, both internally and externally, is submitted to RQIA. The timescale for completion should be identified in each area of proposed work. **Ref: Section 4.3**
	Refurbishment has commenced and the proposed programme of works will be submitted separately
Recommendation 2 **Ref:** Standard 37.1 **Stated:** First time **To be completed by:** 31 May 2016	The registered person should ensure that any record retained in the home which details patient information is stored safely and in accordance with Department of Health (DOH) policy procedures and guidance and best practice standards. **Ref: Section 4.4**
	All resident's records containing their personal details are now stored safely and confidentially and this is being monitored by Home Manager and senior nursing and care staff. All staff supervisions regarding this have been completed.
Recommendation 3 **Ref:** Standard 7.1 **Stated:** First time **To be completed by:** 30 June 2016	The registered person should ensure that a system to seek the views of patients regarding the services provided by the home is established. **Ref: Section 4.4**
	A monthly record of resident's views about the service they receive has been established.An annual survey of residents and relatives views is planned to be carried out in the last quarter of 2016.
Recommendation 4 **Ref:** Standard 35.6 **Stated:** First time **To be completed by:** 30 June 2016	The registered person should ensure that where an area for improvement was identified during audit, an action plan is developed and the area re-audited to verify that the required action had been taken. **Ref: Section 4.6**
	We have now developed a Action Plan which records all audit deficits and other areas which have been highlighted for improvement through internal and external inspection.

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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