The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
1 December 2016

Burleigh Hill House

Type of Service: Nursing Home
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 1 December 2016 from 10.00 to 16.30 hours.

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

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters and staff training and development. Through discussion with staff we were assured that they were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding.

An intense refurbishment programme for the home had been implemented to very good effect.

Staff and patients commented on the staffing arrangements for the home. Whilst these were being addressed by the registered manager a recommendation has been made that the staffing arrangements continue to be monitored.

Is care effective?

We reviewed the systems and processes in place which support effective care delivery.

Following a review of care records areas for improvement were identified and three recommendations were made. We examined the systems in place to promote effective communication between staff and were assured that these systems were robust. Relatives and staff were of the opinion that the care delivered was effective.

Weaknesses have been identified in the patients dining experience and a requirement has been made.

Is care compassionate?

Observations of care delivery evidenced that patients were treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully. Numerous compliments had been received by the home from relatives and former patients. Systems were in place to ensure that patients, and relatives, were involved and communicated with regarding issues affecting them. There were no areas for improvement identified in this domain.

Is the service well led?

There was a clear organisational structure and staff were aware of their roles and responsibilities. A review of care confirmed that the home was operating within the categories of care for which they were registered and in accordance with their Statement of Purpose and Patient Guide.

Staff spoken with were knowledgeable regarding the line management structure and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. Governance arrangements were robust. There were no areas for improvement identified in this domain.

The term 'patients' is used to describe those living in Burleigh Hill House which provides both nursing and residential care.

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	1	4

Details of the Quality Improvement Plan (QIP) within this report were discussed with Emeliza Insauriga, 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 finance inspection undertaken on 30 June 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: MD Healthcare Ltd Lesley Megarity	**Registered manager:** Emeliza Insauriga
Person in charge of the home at the time of inspection: Emeliza Insauriga	**Date manager registered:** 28 October 2016
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

Specific methods/processes used in this inspection include the following:

Prior to inspection we analysed the following information:

- 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, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff. We also met with eight patients, four care staff, two registered nurses, one domestic staff and two patients' representatives.

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 for 2016
- accident and incident records
- audits in relation to for example; care records, infection prevention and control procedures and falls
- complaints received since the previous care inspection
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- minutes of staff, patient and relatives meetings

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 30 June 2016

The most recent inspection of the home was an unannounced finance inspection. The completed QIP was returned and approved by the specialist inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP will be validated at the next medicines management inspection inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 26 April 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 35.6 **Stated:** First time	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. **Action taken as confirmed during the inspection**: Observation of the premises and environment during the inspection confirmed that the action plan submitted to RQIA in respect of upgrading the home was being adhered to. Evidence was present of a significant improvement in the environment of the home both internally and externally.	**Met**
Recommendation 2 **Ref:** Standard 37.1 **Stated:** First time	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. **Action taken as confirmed during the inspection**: Evidence was present of patients dietary information displayed on the wall in the dining rooms, this was discussed with the registered manager who confirmed on 6 December 2016 that any information pertaining to an individual had been removed and could not be viewed by the general public.	**Met**
Recommendation 3 **Ref:** Standard 7.1 **Stated:** First time	The registered person should ensure that a system to seek the views of patients regarding the services provided by the home is established. **Action taken as confirmed during the inspection**: The registered manager had issued questionnaires to patients and evidence was present that where an issue had been raised it had been actioned. It was agreed that the activities coordinators could chair patients meetings in the future.	**Met**

Recommendation 4 **Ref:** Standard 35.6 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Quality audits including infection prevention and control, care records and kitchen audits were reviewed and evidence was present that where remedial action had been identified the appropriate action had been taken and signed by the registered manager.	

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 roster for weeks commencing 28 November and 5 December 2016 evidenced that the planned staffing levels were generally 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. However, some staff spoken with were not 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 there was currently a lot of short notice staff sickness. One patient commented “not enough staff and it takes a while for staff to answer the call bell” and a relative commented via questionnaire “staff always seem to be rushed, safety is first class but washing and dressing is rushed”. Please refer to section 4.5 for further detail.

The staffing arrangements were discussed with the registered manager who stated she was aware of staff concerns and had arranged for a staff meeting to be held the following day, 2 December 2016 to discuss the issues raised by staff. The registered manager should continue to monitor the staffing arrangements for the home and give cognisance to the comments received from staff, patients and relatives in respect of the staffing arrangements. A recommendation has been made.

Discussion with the registered manager and review of training records evidenced that they had a robust system in place to ensure staff attended mandatory training. Staff’s training attendance in respect of; adult safeguarding procedures, moving and handling and fire safety were reviewed. Training records evidenced that training in these areas were either fully completed or scheduled to be completed in December 2016. Observation of the delivery of care evidenced that training had been embedded into practice.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. A review of documentation confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home’s policies and procedures. RQIA were notified appropriately.

Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Action plans were in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since April 2016 confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, and dining room/s and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients, representatives and staff spoken with were complimentary in respect of the home's environment. A robust refurbishment plan had been implemented from April 2016; this had resulted in an enhanced and attractive environment for patients. The registered manager stated some areas of work were still to be completed, for example, replacing the existing passenger lift, and that this was scheduled for January 2017.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Areas for improvement

The registered manager should continue to monitor the staffing arrangements for the home and give cognisance to the comments received from staff, patients and relatives in respect of the staffing arrangements.

Number of requirements	0	Number of recommendations	1

4.4 Is care effective?

A review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Risk assessments informed the care planning process and there was a system in place to ensure that the care plans were developed in consultation with the patient and/or their representative.

Records in relation to the management of wounds/pressure ulcers indicated that when a patient was identified as being at risk of developing a pressure ulcer, a care plan was in place to direct staff on the management of this risk. A wound care management plan had been written for a patient and the progress record evidenced that the wound was healed the following day. In discussion with nursing staff it was stated that the initial wound assessment was incorrect and the patient did not have a pressure ulcer. The care record should have accurately reflected this information and registered nurses should be informed of the importance of recording in a comprehensive manner so as there is no confusion as to the health and wellbeing of any patient. A recommendation has been made.

Where patients were identified as being at risk of dehydration, there was evidence that the totals of food and fluid received were being monitored regularly. A review of patient care records evidenced that patients' total daily fluid intakes were consistently recorded in the daily progress notes.

A review of patient care records evidenced that continence assessments had been completed on admission and this included the patients' individual bowel pattern, reflective of the Bristol Stool Chart. Care staff also recorded patients' bowel movements. However, there was a lack of evidence in one patient's care record that registered nurses were monitoring patients' bowel function. There was evidence of a significant time period elapsing regarding the patient's bowel function and there was no evidence that registered nurses were aware of or had assisted the patient in this area of care. A recommendation has been made that evidence is present in care records that registered nurses are monitoring patients' bowel function

A review of supplementary care records, which included repositioning records, evidenced that staff were not reporting on the condition of patients' skin or if the prescribed topical cream/ointment had been applied. This was discussed with the registered manager and a recommendation has been made.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' condition.

Discussion with the registered manager and a review of the minutes confirmed that staff meetings were held on a quarterly basis or more often if required.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the registered manager.

The serving of the midday meal was observed. Tables were set with cutlery, condiments and napkins in one dining room however the meal service and presentation was not observed to be as organised in the remaining dining rooms. Those patients who had their lunch in the lounge or bedroom were served their meal on a tray which was set with cutlery and fluids but the meal was not covered prior to leaving the dining room on all occasions. The record of menu choice did not evidence that patients who required a modified diet were afforded choice at mealtimes. The most recent quality dining audit of October 2016 was reviewed. The audit stated patients on a modified diet were offered a choice at mealtimes however; this was not found at the time of the inspection. A requirement has been made in relation to the dining experience. Dining tables should be appropriately set, tray service should be improved and patients who require a modified diet must be offered a choice at mealtimes. A requirement has been made.

Areas for improvement

Registered nurses should be informed of the importance of recording in a comprehensive manner so as there is no confusion as to the health and wellbeing of any patient.

Evidence should be present in patient care records that registered nurses are monitoring patients' bowel function and that any prescribed intervention has been actioned.

Supplementary care records, for example, repositioning charts, should evidence that staff are reporting on the condition of patients' skin and that the application of topical creams/ointments has been completed.

The patients dining experience must be reviewed to ensure a consistent approach is adopted and that dining tables are appropriately set and that the tray service is improved. Patients who require a modified diet must be afforded choice at mealtimes.

Number of requirements	1	Number of recommendations	3

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with eight patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner.

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.

We observed a list of activities on the ground floor that included a variety of activities. Information was present in various locations of the home informing patients and relatives of the planned activities, the complaints procedures and numerous advisory leaflets.

During the inspection we met with eight patients, four care staff, two registered nurses, one domestic staff and two patients' representatives. We also issued ten questionnaires to staff and relatives respectively; and eight questionnaires were issued to patients. Two staff, three patients and three patient's representative had returned their questionnaires, within the timeframe for inclusion in this report. Some comments received are detailed below:

Staff

"The care is good."
"There is not enough staff."
"Staff aren't staying."

One staff member commented that "RQIA should increase minimum staffing levels and set a higher number of staff per patient ratio" and that additional staff was needed. RQIA do not 'set' staffing levels in any home. It is the responsibility of the registered manager to ensure there are a sufficient number of, and competent staff on duty, at all times, to meet the needs of the patients. The registered manager should discuss the arrangements for staffing the home at the next staff meeting.

Patients

"Things are so so."
"It is alright here."
"They are very good to me."
"I would go to the manageress if I had any problems."

Patients' representatives

"(My relative) always says that he is happy here."
"We are very pleased."

The returned questions from patients and relatives confirmed that they were either satisfied or very satisfied with the delivery of safe, effective and compassionate care. Relatives and patients were also either satisfied or very satisfied that the service was well led.

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 observation of patients evidenced that the home was operating within its registered categories of care. The registration certificate was displayed appropriately. A certificate of public liability insurance was current and displayed.

Discussion with the registered 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. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Patients were aware of who the manager was

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents and bed rails. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the 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 registered manager and a review of relevant records evidenced that all areas identified in the action plans had been addressed.

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 Emeliza Insauriga, 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.

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">Statutory requirements</td></tr>
<tr><td rowspan="2">Requirement 1

Ref: Regulation 4 (d)

Stated: First time

To be completed by:
16 January 2017</td><td>The registered provider must ensure the dining experience for patients is enhanced in the following areas:
- patients who require a modified diet are afforded a choice at mealtimes
- the presentation of dining tables and the organisation at mealtimes is improved
- tray service is reviewed and improved

Ref: section 4.4</td></tr>
<tr><td>Response by registered provider detailing the actions taken:
- Patients with modified diet are now afforded a choice at meal times, their choice is reflected in the menu list. Diet notification reviewed and updated.
- All dining tables are set appropriately with proper table clothes, condiments and set with cutlery.
- The tray service been reviewed, food covers are provided in dining room. All foods are now covered prior to leaving the dining room.</td></tr>
<tr><td colspan="2">Recommendations</td></tr>
<tr><td rowspan="2">Recommendation 1

Ref: Standard 41.1

Stated: First time

To be completed by:
31 January 2017</td><td>The registered provider should ensure that the staffing arrangements for the home are monitored and cognisance is given to the comments received from staff, patients and relatives in respect of the staffing arrangements.

Ref: section 4.3</td></tr>
<tr><td>Response by registered provider detailing the actions taken:
Staffing arrangement is being monitored closely, new staff have been recruited and have started. Appropriate staffing level is provided to meet residents assessed needs.</td></tr>
<tr><td rowspan="2">Recommendation 2

Ref: Standard 4

Stated: First time

To be completed by:
16 January 2017</td><td>The registered provider should that registered nurses are informed of the importance of recording in a comprehensive manner so as there is no confusion as to the health and wellbeing of any patient, particularly in relation to wound care management..

Ref: section 4.3</td></tr>
<tr><td>Response by registered provider detailing the actions taken:
Accurate and comprehensive recording has been established to avoid confusion as to the health and well being of our residents particularly on wound management. Supervision was conducted with all registered nurses.</td></tr>
</table>

Recommendation 3 **Ref:** Standard 6.15 **Stated:** First time **To be completed by:** 16 January 2017	The registered provider should endure that evidence is present in patient care records that registered nurses are monitoring patients' bowel function and that any prescribed intervention has been actioned. **Ref: section 4.3**
	Response by registered provider detailing the actions taken: Residents bowel function is now being monitored and recorded in their care file (epicare system), reflecting any prescribed intervention that has been actioned. Supervision was conducted with all registered nurses
Recommendation 4 **Ref:** Standard 23 **Stated:** First time **To be completed by:** 16 January 2017	The registered provider should ensure that supplementary care records, for example, repositioning charts, evidence that staff are reporting on the condition of patients' skin and that the application of topical creams/ointments has been completed. **Ref: section 4.3**
	Response by registered provider detailing the actions taken: Residents skin condition is now reflected in repositioning charts. Application of creams/ ointments chart is now completed as prescribed and monitored. Supervision was conducted with all care staff.

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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