Unannounced Care Inspection Report
07 August 2018

Burleigh Hill House

Type of Service: Nursing Home (NH)
Address: 79 North Road, Carrickfergus, BT38 7QZ
Tel No: 02893365652
Inspector: Gerry Colgan

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care and residential care for up to 55 persons.

3.0 Service details

Organisation/Registered Provider: MD Healthcare Ltd **Responsible Individual:** Lesley Catherine Megarity	**Registered Manager:** Emeliza Insauriga
Person in charge at the time of inspection: Emeliza Insauriga	**Date manager registered:** 28 October 2016
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. LD – Learning disability. Residential Care (RC) A – Past or present alcohol dependence. I – Old age not falling within any other category. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of registered places:** 55 A maximum of 22 Residential places. Category NH-LD for 1 identified patient only. Category RC-A for 1 identified resident only.

4.0 Inspection summary

An unannounced inspection took place on 07 August 2018 from 08.20 to 16.30 hours.

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.

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

The inspection assessed progress with any areas for improvement identified 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.

Evidence of good practice was found throughout the inspection in relation to patient activities staffing, staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control and risk management. Further areas of good practice were identified in relation to audits and reviews, communication between residents, staff and other key stakeholders, the culture and ethos of the home, dignity and privacy, listening to and valuing

patients and their representatives, taking account of the views of patients, governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships.

Areas requiring improvement were identified in relation to upgrading a bathroom and toilet and devising care plans for identified care needs.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	2

Details of the Quality Improvement Plan (QIP) 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.

4.2 Action/enforcement taken following the most recent inspection dated 21 November 2017

The most recent inspection of the home was an unannounced care inspection undertaken on 21 November 2017. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report.

During the inspection we met with 20 patients, 10 staff, and two patients' isitors/representatives. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. A poster was provided which directed staff to an online survey and staff not on duty during the inspection.

RQIA involves service users and members of the public as volunteer lay assessors. A lay assessor is a member of the public who will bring their own experience, fresh insight and a

public focus to our inspections. A lay assessor was present during this inspection and their comments are included within this report.

The following records were examined during the inspection:

- duty rota for all staff from 6 August 2018 to 19 August 2018
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment and induction files
- four patient care records
- eight patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits
- complaints record
- compliments received
- RQIA registration certificate
- a sample of monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 21 November 2017

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

6.2 Review of areas for improvement from the last care inspection dated 21 November 2018.

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 41.4 **Stated:** First time	The registered person shall ensure that the competency and capability assessments for a nurse in charge of the home in the absence of the manager evidences regular review/reassessment.	**Met**
	Action taken as confirmed during the inspection: A review of records and conversation with the registered manager confirmed that competency and capability assessments for a nurse in charge of the home in the absence of the manager is subject to regular reassessment.	
Area for improvement 2 **Ref**: Standard 40 **Stated:** First time	The registered person shall ensure that a systematic and quantitative approach to individual staff supervision and annual appraisal is in evidence.	**Met**
	Action taken as confirmed during the inspection: A review of staff personnel files and conversation with staff confirmed that all staff receive regular supervision and annual appraisal.	
Area for improvement 3 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that a social model of care planning is implemented for residential clients.	**Met**
	Action taken as confirmed during the inspection: A review of care records and conversation with the registered manager confirmed that a social model of care planning has been developed in conjunction with the Northern Trust.	

Area for improvement 4 **Ref**: Standard 35.6 **Stated:** First time	The registered person shall ensure that the patient register is maintained in an up to date manner and validated on a regular basis.	**Met**
	Action taken as confirmed during the inspection: Examination of the patient register confirmed that it is properly maintained and reviewed on a weekly basis.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

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 rota from 6 August 2018 to 19 August 2018 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily to meet the needs of the patients and to support the nursing and care staff. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients needs in a timely and caring manner. Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients. Patients spoken with indicated that they were well looked after by the staff and felt safe and happy living in Burleigh Hill House nursing home.

Review of two staff recruitment files evidenced that these were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records also evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work. 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.

A review of records confirmed that a process was in place to monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC. There were systems and processes in place to ensure that alerts issued by Chief Nursing Officer (CNO) were managed appropriately and shared with key staff.

We discussed the provision of mandatory training with staff and reviewed staff training records. Staff confirmed that they were enabled to attend training and that the training provided them with the necessary skills and knowledge to care for the patients. Training records were maintained in accordance with Standard 39 of The Nursing Homes Care Standards. Observation of the delivery of care evidenced that training had been embedded into practice, for example, the moving and handling of patients.

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Discussion with the registered manager confirmed that the regional operational safeguarding policy and procedures were embedded into practice. Systems were in place to collate the information required for the annual adult safeguarding position report.

Review of four patients' care records evidenced that a range of validated risk assessments were completed and reviewed as required. These assessments informed the care planning process.

We reviewed accidents/incidents records from the previous care inspection in comparison with the notifications submitted by the home to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. Records were maintained appropriately and notifications were submitted in accordance with regulation.

Discussion with the registered manager and review of records confirmed that on at least a monthly basis falls occurring in the home were analysed to identify if any patterns or trends were emerging. Following this review an action plan was devised to address any identified deficits. This information was also reviewed as part of the responsible individual's monthly monitoring visit in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. From a review of records, observation of practices and discussion with the registered manager and staff there was evidence of proactive management of falls.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. Fire exits and corridors were observed to be clear of clutter and obstruction. The home was found to be warm, well decorated and fresh smelling. Patients/representatives/staff spoken with were complimentary in respect of the home's environment. However the bath in bathroom 2 was broken at the edge and would need to be replaced and toilet 2 requires repainting and a lock on the door. This is identified as an area for improvement under the standards.

Observation of practices/care delivery, discussion with staff and review of records evidenced that infection prevention and control measures/best practice guidance were adhered to. Systems were in place to monitor the incidents of HCAI's and the manager understood the role of PHA in the management of infectious outbreaks.

A review of records evidenced that appropriate risk assessments had been completed prior to the use of restrictive practices. Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous care inspection confirmed that these were appropriately managed.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control and risk management.

Areas for improvement

An area for improvement was identified in relation to upgrading a bathroom and toilet

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	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Review of four patient care records evidenced that care plans were in place to direct the care required and reflected the assessed needs of the patient. However, in two care records reviewed 'gaps' in recording the delivery of care was evidenced. Care plans had not been devised for a patient who had been prescribed eye drops and another whose needs had recently changed. An area for improvement under the standards was made. We reviewed the management of nutrition, patients' weight, management of infections and wound care. Care records contained details of the specific care requirements in each of the areas reviewed and a daily record was maintained to evidence the delivery of care.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care managers, General Practitioners (GPs), SALT and dieticians. Supplementary care charts such as food and fluid intake records evidenced that contemporaneous records were maintained. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals such as, the tissue viability nurse (TVN), the speech and language therapist (SALT) or the dietician changed.

Discussion with 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 and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

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 or the nurse in charge. All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records. The registered manager advised that patient and/or relatives meetings were held on an annual basis. Minutes were available. Patients and their representatives confirmed that they attended meetings and were aware of the dates of the meetings in advance.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to audits and reviews, communication between residents, staff and other key stakeholders

Areas for improvement

An area for improvement under the standards was identified in relation to devising care plans for identified care needs.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

We arrived in the home at 08.20 hours and were greeted by staff who were helpful and attentive. Patients were enjoying breakfast or a morning cup of tea/coffee in the dining rooms, in one of the lounges or in their bedroom, as was their personal preference. Some patients remained in bed, again in keeping with their personal preference or their assessed needs. Patients had access to fresh water and/or juice and staff were observed assisting patients to enjoy their chosen activity and to eat and drink as required. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required.

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff were also aware of the requirements regarding patient information and patient confidentiality.

Discussion with patients and staff and review of the comprehensive activity programme displayed in the foyer evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. On the morning of the inspection the activity therapists were observed delivering meaningful individual activities to patients and in the afternoon they enjoyed a sing song with a visiting musician in the lounge.

The environment had been adapted to promote positive outcomes for the patients. Bedrooms were personalised with possessions that were meaningful to the patient and reflected their life experiences. A variety of methods were used to promote orientation, for example appropriate signage, photographs, the provision of clocks and prompts for the date.

We observed the serving of the lunchtime meal. Patients were assisted to the dining room or had trays delivered to them as required. Staff were observed assisting patients with their meal appropriately and a registered nurse was overseeing the mealtime. Patients able to communicate indicated that they enjoyed their meal. Staff demonstrated their knowledge of patients' likes and dislikes regarding food and drinks, how to modify fluids and how to care for patients during mealtimes.

There were systems in place to obtain the views of patients and their representatives on the running of the home. Cards and letters of compliment and thanks were displayed in the home Consultation with 20 patients individually, and with others in smaller groups, confirmed that Burleigh Hill House was a good place to live.

Patient comments included:

- "I know it is not home but it is a marvellous place. I get everything I want."

- “We get treated well. I can’t grumble.”
- “Sometimes someone comes around asking about the food. I mentioned that the toast was a bit limp and nothing has changed. That’s not a serious complaint.”
- “By and large everything is good. Sometimes I have to wait for my sleeping pills but that is only on rare occasions.”
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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.

Ten relative questionnaires were provided. None were returned within the timescale.

Staff were asked to complete an on line survey, we had no responses within the timescale

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date were shared with the registered manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the quality of patient activities, the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients

Areas for improvement

There were no areas identified for improvement in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

Since the last inspection there has been no change in management arrangements. A review of the duty rota evidenced that the manager’s hours, and the capacity in which these were worked, were clearly recorded. Discussion with staff/patients/representatives evidenced that the registered manager’s working patterns supported effective engagement with patients, their representatives and the multi-professional team. Staff were able to identify the person in charge of the home in the absence of the registered manager/manager.

We discussed the arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. The equality data collected was managed in line with best practice.

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

Discussion with the registered manager and review of records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents, IPC practices, care records, catering arrangements. In addition robust measures were also in place to provide the registered manager with an overview of the management of infections, wounds occurring in the home.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed on a monthly basis by the responsible individual in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005/ *The Care Standards for Nursing Homes.*

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

Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships.

Areas for improvement

There were no areas identified for improvement in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement 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 if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 44 **Stated:** First time **To be completed by:** 30 September 2018	The registered person shall repair or replace the bath in bathroom 2 and fit a lock on the door and repaint toilet 2. Ref: Section 6.4
	Response by registered person detailing the actions taken: Toilet 2 has now been repainted. A lock has been fitted on the door of bathroom 2. The bath in bathroom 2 will be replaced.
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 31 August 2018	The registered person shall ensure that care plans are developed to reflect the current needs of patients. Ref: Section. 6.5
	Response by registered person detailing the actions taken: Care plans have been reviewed and appropriate actions are in place to ensure care plans are developed to reflect the current needs of residents.

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

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