Unannounced Care Inspection Report
21 November 2017

Burleigh Hill House

Type of Service: Nursing Home (NH)
Address: 79 North Road, Carrickfergus, BT38 7QZ
Tel no: 028 9336 5652
Inspector: Heather Sleator

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 56 persons.

3.0 Service details

Organisation/Registered Provider: MD Healthcare Ltd **Responsible Individual:** Mrs Lesley 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. LD – Learning disability. PH – Physical disability other than sensory impairment. 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:** 56 comprising: 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 21 November 2017 from 09.40 to 17.45 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 ‘patients’ 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 in relation to staff recruitment practices; staff induction, training and development; infection prevention and control practices; risk management and effective communication systems. The culture and ethos of the home promoted treating patients with dignity and respect. There was also evidence of good practice identified in relation to the governance and management arrangements; management of complaints and incidents; quality improvement processes and maintaining good relationships within the home. The environment of the home was conducive to the needs of the patients and was attractive and comfortable.

Areas requiring improvement were identified under the care standards and included implementing a social model of care planning for residential clients, the regular review of the competency and capability assessment for the nurse in charge of the home in the absence of the manager, a more systematic and quantitative approach to the recording of individual staff supervision and annual appraisal and evidencing the validation of the patient register on a regular basis.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings. Patients' comments included, "This is my home." Refer to section 6.6 for further comments.

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	4

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 14 September 2017

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 14 September 2017.

There were no further actions required to be taken following the most recent 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 the inspector met with 18 patients and six staff. There were no patients' visitors/representatives who wished to meet with the inspector during the inspection. Ten questionnaires for staff and relatives and eight for patients were left for distribution. A poster informing staff of how to submit their comments electronically, if so wished, was given to the registered manager to display in the staff room.

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following records were examined during the inspection:

- duty rota for all staff from 13 to 26 November 2017
- 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
- three patient care records
- three patient care charts including food and fluid intake charts and reposition charts
- staff supervision and appraisal planners
- a selection of governance audits
- patient register
- complaints record
- compliments received
- RQIA registration certificate
- certificate of public liability
- 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.

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 14 September 2017

The most recent inspection of the home was an unannounced medicines management inspection. No areas for improvement were identified.

6.2 Review of areas for improvement from the last care inspection dated 1 December 2016

<table>
<tr><th colspan="3">Areas for improvement from the last care inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td>Area for improvement 1

Ref: Regulation 4 (d)

Stated: First time</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</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Observation of the serving of the midday meal and a review of records evidenced that all areas previously identified had been addressed.</td></tr>
<tr><th colspan="2">Action required to ensure compliance with The Care Standards for Nursing Homes (2015)</th><th>Validation of compliance</th></tr>
<tr><td>Area for improvement 1

Ref: Standard 41.1

Stated: First time</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.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The review of the staffing arrangements confirmed that planned staffing was adhered to. Staff did not raise any issue of concern regarding the staffing arrangements during the inspection.</td></tr>
</table>

Area for improvement 2 **Ref**: Standard 4 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: The review of three patient care records evidenced that wound care management was in accordance with professional guidelines and standards.	
Area for improvement 3 **Ref**: Standard 6.15 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: The review of records evidenced that patients' bowel movements were monitored by the registered nurses on a daily basis, using the Bristol Stool guidance as a reference, to ensure that any changes from the patients' usual bowel patterns were identified and timely action taken.	
Area for improvement 4 **Ref**: Standard 23 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: The review of supplementary care records evidenced that staff were reporting on the condition of patients' skin at repositioning. A number of staff had also completed training on the application of topical medicines.	

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 staffing was subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from 13 November to 26 November 2017 evidenced that the planned staffing levels were adhered to. The review of the staffing rosters evidenced that there were ancillary staff on duty throughout the seven day period. Observation of the delivery of care and discussion with staff evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. We also sought staffs' opinion on staffing arrangements via questionnaires; none were returned prior to the issue of this report. One staff member stated during the inspection, "This is the best the home has ever been". Three relatives also responded via questionnaire and confirmed their satisfaction with the staffing arrangements.

A review of three records evidenced that a competency and capability assessment had been completed with nurses who were given the responsibility of being in charge of the home in the absence of the manager. The assessments viewed did not evidence that they had been reviewed/reassessed on a regular basis with one assessment not having been reviewed from September 2015. This was discussed with the registered manager as an area for improvement under the care standards.

Discussion with the registered manager and a review of two staff personnel files evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. Where nurses and carers were employed, their registrations were checked with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC), to ensure that they were suitable for employment. The review of recruitment records evidenced that enhanced criminal records checks were completed with Access NI and satisfactory references had been sought and received, prior to the staff member starting their employment.

The registered manager confirmed that newly appointed staff commenced a structured orientation and induction programme at the beginning of their employment. A review of two completed induction programmes evidenced that these were completed within a meaningful timeframe

The arrangements in place to confirm and monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC were discussed with the registered manager and reviewed. The review of the records evidenced that a robust system was in place to monitor the registration status of nursing and care staff.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and records were kept up to date. A review of staff training records confirmed that staff completed electronic training modules on for example; basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult prevention and protection from harm. The records reviewed confirmed that the manager had a system in place to ensure staff met their mandatory training requirements. Evidence was present that staff had completed other areas of training provided by the local Trust and included; stoma care, urinary catheterisation and guidance in respect of enteral feeding.

A review of the supervision and appraisal schedule confirmed that there were systems in place to ensure that staff received supervision and appraisal. However and as discussed with the registered manager a more systematic approach to the planning of supervision and appraisal would be of benefit as the system in operation did not clearly quantify that all staff had been in receipt of individual supervision and an annual appraisal. This has been identified as an area for improvement under the care standards.

The registered manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. The registered manager stated that both she and the deputy director of the organisation had attended specific safeguarding training which included the role of the safeguarding champion. The registered manager stated that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. The adult safeguarding policy reflected the new regional operational procedures.

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. There was evidence that risk assessments informed the care planning process. Care records are further discussed in section 6.5.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since December 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, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout.

Infection prevention and control measures were adhered to. Sluice rooms and bathroom/toilets were observed to be clutter free and well organised. Personal protective equipment (PPE) such as gloves and aprons were available throughout the home and stored appropriately.

Fire exits and corridors were observed to be clear of clutter and obstruction. The annual fire risk assessment of the home was undertaken on 10 August 2017. Discussion with the registered manager and a review of documentation evidenced that the recommendations of the report had been addressed.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the management and provision of staffing, recruitment and selection procedures, staff training and development, infection prevention and control and fire safety.

Areas for improvement

The following areas were identified for improvement under the care standards. The competency and capability assessments for a nurse in charge of the home in the absence of the manager should evidence review/reassessment on a regular basis and a more systematic and quantitative approach to staff appraisal and supervision should be in evidence.

	Regulations	Standards
Total number of areas for improvement	0	2

6.5 Is care effective?

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

Review of three patient care records evidenced improvements in care planning and review and that care plans were in place to direct the care required. Nursing staff spoken with were aware of professional requirements to review and update care plans as the needs of patients' change. Senior care assistants have the responsibility for care panning and review for the residential clients in the home. The review of the residential care records evidenced that the nursing process is utilised. A social care model of care planning for residential clients would be of benefit. This has been identified as an area for improvement.

There were a number of examples of good practice found throughout the inspection in this domain. For example, registered nurses were aware of the local arrangements and referral process to access other relevant professionals including General Practitioner's (GP), Speech and Language Therapist (SALT) and Tissue Viability Nurse Specialists (TVN). Discussion with registered nurses and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

Personal or supplementary care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans, the frequency of repositioning was recorded on the repositioning record and staff were reporting on the condition of the patient's skin. Staff described their responsibilities regarding the maintenance of the supplementary care records and were knowledgeable regarding the rational for monitoring patients' weight loss and the referral process to health care professionals were weight loss was evidenced.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. Patients' records were maintained in accordance with Schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005.

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.

Patients' records were maintained in accordance with Schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005; the registered manager confirmed that the patient register was checked on a regular basis however the register did not evidence that the information had been validated by the registered manager of the deputy director when completing the monthly monitoring visit. This has been identified as an area for improvement. The registered manager agreed to ensure that this is done in the future. A separate register is maintained for residential clients.

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.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and discussions at the handover provided the necessary information regarding any changes in patients' condition. Staff also confirmed that communication between all staff grades was effective.

Staff meetings were held on a fairly regular basis and records were maintained and made available to those who were unable to attend. The most recent staff meeting was 16 June 2017, with a meeting scheduled for December 2017. Staff stated that there was effective teamwork with each staff member knew their role, function and responsibilities. Refer to section 6.6 for further staff comment.

The serving of the midday meal was observed. Meals were served in the dining rooms on the ground and first floors. Patients who required a modified diet were afforded a choice at mealtimes; this was verified when reviewing the patients' meal choice record. Tables were attractively set with cutlery and napkins. The meals were nicely presented, were of good quality and smelt appetising. The day's menu was displayed in the dining rooms. Registered nurses were observed supervising and assisting patients with their meals and monitoring patients' nutritional intake.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping, communication between residents, staff and other key stakeholders and the dining experience.

Areas for improvement

The following areas identified for improvement were in relation to implementing a social care model of care planning for residential clients and ensuring the patient register is reviewed and validated on a regular basis.

	Regulations	Standards
Total number of areas for improvement	0	2

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 09:40. There was a calm atmosphere and staff were busy attending to the needs of the patients. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

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. Staff were knowledgeable of patients' non-verbal cues and what they were trying to communicate; the positive non-verbal responses by patients confirmed staffs understanding was correct.

There is a varied and interesting activities programme in place. The activities programme was displayed on both floors of the home and a copy of the home's monthly newsletter was available in each patient's bedroom. There were various sources of information displayed in the entrance lobby including a monitor on the wall informing of the day's activities, a suggestions box, invite to the scheduled relatives meeting on 6 December 2017 and a number of health promotion leaflets.

Numerous compliments had been received and were displayed in the home in the form of thank you cards. The following are examples of comments received on thank you cards:

"I knew you all genuinely care and that means so much, especially at the times when I didn't know which way to turn."
"Thank you for your time, patience, understanding and the occasional laugh."
"Thank you so much for taking care of our (relative)."

We spoke to patients who commented:

"I would recommend this home, great place."
"Staff come whenever I need them."
"The manager is a good girl, always listens to me."
"Can be a long day but I sometimes go to the activities."
"The food is generally good."
"Staff are all wonderful."
"Activities girls are very good."
"Generally speaking the staff are excellent."
"This is my home."

We spoke with staff who commented that they felt there had been an improvement in the home, they felt confident they would be listened to if they brought any issues to management and team work in the home was much better.

Questionnaires

In addition, ten relative/representatives and ten patient questionnaires were provided by RQIA to the manager for distribution. At the time of issuing this report, three relatives returned their questionnaires within the specified timeframe. Two relatives indicated that they were very satisfied that the delivery of care was safe, effective and compassionate and that the service was well led. One relative was satisfied that care was safe, effective and compassionate and that the home was well led. There were no additional comments made.

There were no staff questionnaires returned with the timeframe.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to 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 the patients 'and the provision of activities.

Areas for improvement

No areas for improvement were identified during the inspection.

	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.

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 up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

Discussions with the staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. Staff described how they felt confident that the management would respond positively to any concerns/suggestions raised.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. There was a system in place to identify the person in charge of the home, in the absence of the manager.

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 Care Standards for Nursing Homes 2015. Staff, patients and patients' representatives who responded via questionnaire that that were confident that staff/management would manage any concern raised by them appropriately.

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.

A review of the patient falls audit evidenced that this was analysed to identify patterns and trends, on a monthly basis. An action plan was 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 the previous care inspection, confirmed that these were appropriately managed. There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner. These included medication and equipment alerts and alerts regarding staff that had sanctions imposed on their employment by professional bodies.

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 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 plan had been addressed.

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 within the home.

Areas for improvement

No areas for improvement were identified during the inspection.

	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 Care Standards for Nursing Homes (2015).

Area for improvement 1 **Ref**: Standard 41.4 **Stated:** First time **To be completed by:** 13 January 2018	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. Ref: Section 6.4
	Response by registered person detailing the actions taken: The competency and capability assessment for nurse in charge of the home in the absence of the home manager is now reviewed, updated Personnel competency assessments have been reviewed and updated and will be further reviewed regularly.
Area for improvement 2 **Ref**: Standard 40 **Stated:** First time **To be completed by:** 13 January 2018	The registered person shall ensure that a systematic and quantitative approach to individual staff supervision and annual appraisal is in evidence. Ref: Section 6.4
	Response by registered person detailing the actions taken: A systematic and quantitative approach to individual staff supervision and annual appraisal is now in place.
Area for improvement 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 1 February 2018	The registered person shall ensure that a social model of care planning is implemented for residential clients. Ref: Section 6.5
	Response by registered person detailing the actions taken: Appropriate actions are being taken to ensure that a new model of social care planning is developed and introduced for residential clients. We are meeting with Trust commissioning partners on this matter in late January 2018.
Area for improvement 4 **Ref**: Standard 35.6 **Stated:** First time **To be completed by:** 13 January 2018	The registered person shall ensure that the patient register is maintained in an up to date manner and validated on a regular basis. Ref: Section 6.5
	Response by registered person detailing the actions taken: The patient (residents) register book is now maintained up to date, validated and signed on regular basis.

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

The Regulation and Quality Improvement Authority

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