The Regulation and Quality Improvement Authority

Inspection Report

28 October 2021

Burleigh Hill House

Type of service: Nursing Home
Address: 76 North Road,
Carrickfergus, BT38 7QZ
Telephone number: 028 9336 5652

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: MD Healthcare Ltd. **Responsible Individual:** Mrs Lesley Catherine Megarity	**Registered Manager:** Mrs Emeliza Insauriga **Date registered:** 28 October 2016
Person in charge at the time of inspection: Mrs Emeliza Insauriga – Registered Manager	**Number of registered places:** 35 The total number of registered beds will decrease to 33 once an identified nursing patient is no longer accommodated in room 44. Category NH-LD for 1 identified patient only.
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. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 28
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 35 patients. Patients' bedrooms, communal lounges and dining rooms are located over two floors. A Residential Care Home is located within the Nursing Home and the Registered Manager for this home manages both services.	

2.0 Inspection summary

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

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

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

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

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

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

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

3.0 How we inspect

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

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

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

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

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

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

4.0 What people told us about the service

During the inspection we spoke with 15 patients, eight staff and three relatives.

Patients said that they felt well looked after and that staff were helpful and friendly. One patient said "I love it here, I am so well looked after, absolutely no complaints".

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

Relatives commented very positively about the care provided for their loved ones, the staff and communication. One relative said “the staff go over and above” and another commented that “staff are excellent”.

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

Nine completed questionnaires were received; all the respondents indicated that they were satisfied/very satisfied that the care provided was safe, effective, compassionate and well led. Relatives commented that “when I chose this nursing home I made the right decision”, “everything is excellent”, “home from home treatment” and “all the staff show great compassion”.

No staff responded via the online survey.

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

5.0 The inspection

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

Areas for improvement from the last inspection on 23 November 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 30 **Stated:** First time	The registered person shall ensure that RQIA is informed of all notifiable accidents/incidents appropriately.	**Met**
	Action taken as confirmed during the inspection: Review of records confirmed that this area for improvement had been met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. Review of recruitment records revealed that there was no evidence of an Enhanced Access NI check having been completed in one file.

In two files it was noted that references had been sought from the most recent homes in which the employees had worked through an agency, but not actually from the agency, their most recent employer. An area for improvement was identified. Following the inspection the manager confirmed that an Enhanced Access NI check had been appropriately completed for the identified employee and the reference issues had been explored.

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

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

The staff duty rota accurately reflected the staff working in the home on a daily basis. The duty rota identified the person in charge when the manager was not on duty.

Staff said that teamwork was good and that there was enough staff on duty to meet the needs of the patients. The manager told us that the number of staff on duty was reviewed on at least a monthly basis to ensure the needs of the patients were met. It was noted that there was enough staff in the home to respond to the needs of the patients in a timely way.

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

Patients said that there were enough staff to help them although one patient said that they sometimes had a bit of a wait for assistance at night time and they felt more night duty staff might be required.

5.2.2 Care Delivery and Record Keeping

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

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

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

Patients who are less able to mobilise were assisted by staff to mobilise or change their position regularly. Care records accurately reflected the patients' needs and included recommendations from the Physiotherapist and Occupational Therapist (OT) if required. It was observed that while records of patients' repositioning were up to date they were not always signed by two staff as required. This was brought to the attention of the manager for information and action. Following the inspection the manager confirmed that supervision had been held with staff regarding accurate signing of repositioning records.

Review of wound care records evidenced that these were contemporaneously recorded and reflective of the relevant wound care plans. Referrals had been made to the Tissue Viability Nurse (TVN) if required and their recommendations were clearly recorded.

It was observed that the care records for an identified patient needed to be updated to reflect some recent changes; this was brought to the attention of staff and following the inspection the manager confirmed that the care records had been appropriately updated.

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

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

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

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

Patients said that they very much enjoyed the food provided and did not raise any concerns about the provision of drinks. During the inspection it was observed that drinks and snacks were offered regularly and that jugs of juice were provided in patients' bedrooms. It was also observed that staff thickened patients' fluids if this was required and took time to assist those patients who required help to take a drink.

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

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

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

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

Patients' individual likes and preferences were reflected throughout the records. The care plans were detailed and contained specific information on each patients' care needs and what or who was important to them. Care plans reviewed included information regarding, for example, preferred activities, the type of music the patient enjoys and sleeping preferences.

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

Patients said that they felt well looked after by the staff who were helpful and friendly.

5.2.3 Management of the Environment and Infection Prevention and Control

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

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

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

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

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

Patients said that the home was kept clean and tidy.

5.2.4 Quality of Life for Patients

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

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

Patients told us that staff listened to them, offered choices throughout the day and helped sort out any concerns they might have. Patients said that staff were "just great" and "lovely".

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

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

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

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

The atmosphere in the home was friendly and pleasant and staff were seen to be attentive to the patients and to answer requests for assistance promptly. Patients who were in their rooms had call bells within reach.

A relative complimented all the staff including the manager, reception staff, activity coordinators and the visiting champions on the great first impression they all presented for the home. Relatives said communication was very good, care was great, any concerns were quickly sorted out and the manager was very approachable.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection. Mrs Emeliza Insauriga has been the Registered Manager in this home since 28 October 2016. Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about patients, care practices or the environment.

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

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

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

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

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

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

6.0 Conclusion

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

The home was clean, tidy, warm and welcoming.

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

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

7.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	1	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Emeliza Insauriga, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 21 **Stated:** First time **To be completed by:** Ongoing from the date of the inspection.	The registered person shall ensure that recruitment records contain evidence of an Enhanced Access NI check. Additionally, one of the two references required should be sought from the present or most recent employer, this includes agency employment. Ref: 5.2.1
	Response by registered person detailing the actions taken: The Enhanced Access NI check had been fully competed for this identified staff record prior to employment, however the details had not been transcribed onto the staffs personell record, the manager will monitor this area for future record keeping. In regard to the reference, this was a genuine oversight, as the staff member had solely worked in one care home for approximately two years, however this was through an agency, we obtained a reference directly from this care home and not from the agency. Processes are now in place to ensure this mistake does not occur again. The Home Manager will keep this under review.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 4.9 **Stated:** First time	The registered person shall ensure that the recommended consistency of diet and fluids is recorded on the patients' food and fluid intake booklets. Ref: 5.2.2

To be completed by: Ongoing from the date of the inspection.	**Response by registered person detailing the actions taken:** This was actioned immediately following the Care Inspection, all records now have the recommended consistency of diet and fluids recorded on each resident's food and fluid intake booklets. The Home Manager will continue to monitor this through the auditing process
Area for improvement 2 **Ref:** Standard 4.9 **Stated:** First time	The registered person shall ensure that night duty staff accurately and contemporaneously record patients' fluid intake. Ref: 5.2.2
To be completed by: Ongoing from the date of the inspection.	Supervision sessions have been carried out with staff to highlight the importance of recording accurately and contemporaneously all resident fluid intake. The Home Manager will monitor this through the auditing process

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

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