

Inspection Report

Name of Service:	Burleigh Hill House
Provider:	MD Healthcare Ltd
Date of Inspection:	29 October 2025

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/Responsible Person:	Mrs Lesley Megarity
Registered Manager:	Mrs Emeliza Insauriga
<p>Service Profile – This home is a registered nursing home which provides nursing care for patients with a physical disability under and over the age of 65 and general nursing care for up to 35 patients. Patients’ bedrooms, communal lounges and dining rooms are located over two floors.</p> <p>A residential care home is located within the nursing home and the Registered Manager for this home manages both services.</p>	

2.0 Inspection summary

An unannounced inspection took place on 29 October 2025, from 9.35 am to 5.30 pm by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection evidenced that safe, effective and compassionate care was delivered to patients and that the home was well led. Details and examples of the inspection findings can be found in the main body of the report.

It was established that staff promoted the dignity and well-being of patients and that staff were knowledgeable and well trained to deliver safe and effective care.

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

This inspection resulted in two new areas for improvement being identified.

3.0 The inspection

3.1 How we Inspect

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

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patients, relatives, staff or the commissioning Trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards. Inspectors will also observe care delivery and may conduct a formal structured observation during the inspection.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Patients told us that staff offered choices to them throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options, and where and how they wished to spend their time. The patients were happy to engage with the inspector and talk about their experience of living in Burleigh Hill House, they told us; "I am dead on , the staff are dead on", "I am well looked after", "the staff are very good" and "everyone is very good to me".

Three relatives completed and returned questionnaires; all the comments included were very positive. The comments included were; "We have no complaints about the care given", "I am very happy and content with the care provided" and "Whatever is required is given".

Staff spoken with said that Burleigh Hill House was a good place to work, they felt supported and reported that teamwork was good. Staff also commented positively about the manager and described them as very supportive and approachable. Discussion with the manager and staff confirmed that there were good working relationships between staff and management. All comments from staff were passed to the manager for review.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of patients. Review of one recruitment file evidenced that the person's full employment history and gaps in employment were not complete. An area for improvement was identified.

There was a system in place to monitor that all relevant staff were registered with the Nursing and Midwifery Council (NMC) or the Northern Ireland Social Care Council (NISCC). Records showed that any nurse taking charge of the home had competency and capability assessments reviewed annually, to ensure they held the knowledge and skills required.

Patients said that there was enough staff on duty to help them. Staff said there was good team work and that they felt well supported in their role and that they were satisfied with the staffing levels.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty and it was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

3.3.2 Quality of Life and Care Delivery

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff interactions with patients were observed to be polite, friendly, warm and supportive and the atmosphere was relaxed, pleasant and friendly. Staff were knowledgeable of individual patients' needs, their daily routine, wishes and preferences.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner, and by offering personal care to patients discreetly. Staff were also observed offering patient choice in how and where they spent their day or how they wanted to engage socially with others.

At times, some patients may require the use of equipment that could be considered restrictive or they may live in a unit that is secure to keep them safe. It was established that safe systems were in place to safeguard patients and to manage this aspect of care.

Patients may require special attention to their skin care. These patients were assisted by staff to change their position regularly and care records accurately reflected the patients' assessed needs.

Examination of care records and discussion with the manager confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed.

Good nutrition and a positive dining experience are important to the health and social wellbeing

of patients. Patients may need a range of support with meals; this may include simple encouragement through to full assistance from staff and their diet modified.

Observation of the lunchtime meal served in the main dining room confirmed that there were enough staff present to support patients with their meal, the food served smelt and looked appetising and nutritious.

It was observed that staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed. The patients commented positively about the food in Burleigh Hill House.

The importance of engaging with patients was well understood by the manager and staff. The home has dedicated activity staff employed. A number of patients were observed in the lounge enjoying a baking activity. A patient told us later in the day "I really enjoyed the soda bread".

Observation of this planned activity confirmed that staff knew and understood patients' preferences and wishes. Other patients were observed in their bedrooms with their chosen activity such as reading, listening to music or watching television.

Patients' needs were met through a range of individual and group activities such as games, arts and crafts, hairdressing, one to one time and baking.

3.3.3 Management of Care Records

Patients' needs were assessed by a nurse 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 included any advice or recommendations made by other healthcare professionals.

Patients care records were held confidentially.

A review of care records evidenced deficits in the detail in care plans for bespoke one to one care and for one patient identified as a risk of falls, they did not have a care plan in place to reflect this need. It was observed that these deficits had not been identified through the care record audit. Details were discussed with the manager and an area for improvement in regards to the auditing process was identified.

Wound care records reviewed for one patient who had two wounds only had one care plan in place to direct care. Detail was discussed with the manager and addressed at the time of inspection.

3.3.4 Quality and Management of Patients' Environment Control

Examination of the home's environment included reviewing a sample of bedrooms, bathrooms, storage spaces and communal areas such as lounges. The home was warm, comfortable and welcoming. Patients' bedrooms were tidy and personalised with items of importance to each patient, such as family photos and sentimental items from home. The home was tastefully decorated for Halloween and the manager discussed plans for the Christmas period.

Review of records and discussion with the manager confirmed that environmental and safety checks were carried out, as required on a regular basis.

Review of records and observations confirmed that systems and processes were in place to manage infection prevention and control which included policies and procedures and regular monitoring of the environment and staff practice to ensure compliance.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Emeliza Insaoriga has been the registered manager in this home since 28 October 2016. Staff commented positively about the manager and described her as supportive, approachable and able to provide guidance.

Review of a sample of records evidenced that a system for reviewing the quality of care, other services and staff practices was in place. There was evidence that the management team responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and/or the quality of services provided by the home.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	0	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Emeliza Insaoriga, 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 Care Standards for Nursing Homes (December 2022)	
<p>Area for improvement 1</p> <p>Ref: Standard 38</p> <p>Stated: First time</p> <p>To be completed by: 29 October 2025</p>	<p>The Registered Person shall ensure all pre-employment checks for newly recruited staff are in place prior to the commencement of employment. This is stated in reference but not limited to gaps in employment and reasons for leaving</p> <p>Ref: 3.3.1</p>
	<p>Response by registered person detailing the actions taken: This was in relation to a single recruitment record and had unfortunately been an oversight. We will ensure that all appropriate pre-employment checks are made before an individual commences work. Ongoing compliance will be monitored by both the Home Manager and the Human Resources department to ensure this is consistently maintained.</p>
<p>Area for improvement 2</p> <p>Ref: Standard 35</p> <p>Stated: First time</p> <p>To be completed by: 29 December 2025</p>	<p>The Registered Person shall ensure that the care record audit is reviewed to ensure deficits as seen on inspection are identified.</p> <p>Ref: 3.3.3</p>
	<p>Response by registered person detailing the actions taken: The care record audit tool has been reviewed and updated to ensure deficits, as discussed on the day of the inspection, are clearly identified. A meeting was held with all nursing staff to discuss the importance of maintaining person centred care plans and accurate documentation. This area will be closely monitored by the Home Manager and Deputy Manager to ensure sustained improvement and ongoing compliance.</p>

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



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