Silverdale
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Unannounced Care Inspection of Silverdale

29 June 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 29 June 2015 from 12.55 to 17.45.

This inspection was underpinned by **Standard 19 - Communicating Effectively; Standard 20 – Death and Dying and Standard 32 - Palliative and End of Life Care.**

Overall on the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no significant areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of this report.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 9 June 2014.

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	1

The details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Geraldine Browne, registered manager and Ms Val Humphreys, nursing sister as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: SRB Care Limited/Mrs Sarah Roberta Brownlee	Registered Manager: Mrs Geraldine Browne
Person in Charge of the Home at the Time of Inspection: Mrs Geraldine Browne	**Date Manager Registered:** 10 June 2009
Categories of Care: NH-DE, NH-I, NH-PH	**Number of Registered Places:** 41
Number of Patients Accommodated on Day of Inspection: 41	**Weekly Tariff at Time of Inspection:** £614.00 - £644.00

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standards and theme have been met:

Standard 19: Communicating Effectively
Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

4. Methods/Process

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

Prior to inspection the following records were analysed:
- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous inspection
- the returned Quality Improvement Plan (QIP) from the care inspection undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection, the inspector met with 20 patients, five care staff, two nursing staff, two ancillary staff, one visiting professional and three patients' representatives.

The following records were examined during the inspection:

- validation evidence linked to the previous care inspection QIP
- the staff duty rota
- three patient care records
- two repositioning charts
- staff training records
- staff induction records
- best practice guidance for communication and palliative care
- complaints/compliments records

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced pharmacy inspection dated 29 September 2014. The completed QIP was returned and approved by the pharmacy inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 20 (1) (c) (i)	The registered provider shall ensure that staff are trained in the following areas: • Enteral Feeding Systems (registered nurses as appropriate) • Pressure area Care and Prevention (care assistants)	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of the training records evidenced that staff had attended training in enteral feeding systems in August 2014 and November 2014 and pressure area care training in February 2015 and March 2015.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 12.10	It is recommended that patients' recommended daily fluid targets and the action to be taken if these targets are not being achieved be recorded in patients' care plans on eating and drinking. It is also recommended that patients' total fluid intake for each 24 hour period be recorded in the evaluations of care and treatment provided to patients.	**Met**
	Action taken as confirmed during the inspection: A review of three patients' care records and discussion with the registered nurses evidenced that the total daily fluid intake for patients is recorded in the progress notes and actions taken if the target is not achieved is also recorded.	
Recommendation 2 **Ref**: Standard 5.3	It is recommended that patients' repositioning charts are recorded appropriately.	**Met**
	Action taken as confirmed during the inspection: A review of two patients' repositioning charts and discussion with a member of care staff evidenced that repositioning charts have been accurately completed in a timely manner.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was available on communicating effectively which reflected current best practice, including regional guidelines on Breaking Bad News. Discussion with three staff confirmed that they were knowledgeable regarding this policy and procedure.

A review of staff training records and discussion with the registered manager evidenced that staff had completed training in April and May 2015 in relation to communicating effectively with patients and their families/representatives. This training included the procedure for breaking bad news as relevant to staff roles and responsibilities.

Is Care Effective? (Quality of Management)

Three nursing care records evidenced that patients' individual needs and wishes in regards to daily living were appropriately recorded.

Recording within care records did include reference to the patient's specific communication needs.

There was evidence within all records reviewed that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs.

Registered nursing staff consulted, demonstrated their ability to communicate sensitively with patients and/or their representative when breaking bad news. They advised that in the past they spent time with the patient or family member in a private area, using a calm voice, spoke in an empathetic manner using clear speech, offering reassurance and an opportunity for the patient or family member to ask any questions or voice any concerns. Care staff were also knowledgeable on how to break bad news and offered similar examples when they have supported patients when delivering bad news.

Is Care Compassionate? (Quality of Care)

Observation of the delivery of care and staff interactions with patients, confirmed that communication was well maintained and patients were observed to be treated with dignity and respect. There were a number of occasions when patients had been assisted to redirect their anxieties by care staff in a very positive and professional way. It was evident that staff had developed strong and supportive relationships with patients and their representatives. Staff were observed explaining, reassuring and offering assistance to patients in a calm and unhurried manner.

The inspection process allowed for consultation with 20 patients individually and with many others in small groups. In general the patients all stated that they were very happy with the quality of care delivered within Silverdale. They confirmed that staff were polite and courteous and that they felt safe in the home.

Two patient's representatives and one visiting professional discussed care delivery and confirmed that they were very happy with standards maintained in the home. One patient's representative requested a questionnaire to complete and informed the inspector that the questionnaire would be posted to RQIA. A representative questionnaire was subsequently returned to RQIA following the inspection. The issues identified were discussed with the registered person following the inspection to address.

Several patients and representatives comments are recorded in section 5.5.3 below.

A number of compliment cards were available from past family members. There was evidence within compliments/records that relatives had commended the management and staff for their efforts towards the family and patient.

Areas for Improvement

There were no areas of improvement are identified for the home in respect of communication.

Number of Requirements:	**0**	**Number of Recommendations**:	**0**

5.4 Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

Is Care Safe? (Quality of Life)

Policies and procedures on the management of palliative and end of life care and death and dying were available in the home. These documents reflected best practice guidance such as the Gain Palliative Care Guidelines, November 2013, and included guidance on the management of the deceased person's belongings and personal effects.

Training records evidenced that staff were trained in the management of death, dying and bereavement. Registered nursing and care staff were aware of and able to demonstrate knowledge of the Gain Palliative Care Guidelines, November 2013.

A review of training records evidenced that a number of staff had completed training in respect of palliative/end of life care at a seminar organised by Mrs Brownlee, registered person during June 2015. Discussion with staff who attended confirmed that specialist speakers were invited to deliver talks on spiritual care, the role of the G.P, delivering palliative care and the role of the palliative care nurse within the trust. This is commended.

Discussion with registered nursing staff confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services. Information leaflets regarding the palliative care team in the local trust were available in the home.

Discussion with the registered manager, nursing staff and a review of three care records evidenced that staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken.

A protocol for timely access to any specialist equipment or drugs was in place and discussion with registered nursing staff confirmed their knowledge of the protocol.

The palliative care link nurse within the home is Mrs Geraldine Browne registered manager.

Is Care Effective? (Quality of Management)

A review of three care records evidenced that patients' needs for palliative and end of life care were assessed and reviewed on an ongoing basis. This included the management of hydration and nutrition, pain management and symptom management. There was evidence that the patient's wishes and their social, cultural and religious preferences were also considered. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements.

A named nurse was identified for each patient approaching end of life care. There was evidence that referrals had been made to the specialist palliative care team and where instructions had been provided, these were evidently adhered to.

It was confirmed that environmental factors had been considered when a patient was considered end of life. Staff consulted confirmed that management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying. Facilities have been made available for family members to spend extended periods with their loved ones during the final days of life. Patient representatives were able to stay overnight in the home if required. Meals, snacks and emotional support have been provided by the staff team.

A review of notifications of death to RQIA during the previous inspection year evidenced that all had been reported appropriately.

Is Care Compassionate? (Quality of Care)

Arrangements were in place in the home to facilitate, as far as possible the patient's wishes for family/friends to spend as much time as they wish with the person. Discussion with a member of care staff confirmed that any patient who did not have family locally would not be left to die alone as staff would be made available to sit with the patient, hold their hand and spend time with them during the final hours of life. The member of staff demonstrated how they ensure the end of life for each patient is as dignified as possible.

All staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death. This included attending the funeral service of a patient.

From discussion with the registered manager and staff, it was evident that arrangements were in place to support staff following the death of a patient. The arrangements included one to one support from the registered manager, nursing sister and support through staff meetings and staff supervision sessions.

Information regarding bereavement support services was available and accessible for staff, patients and their relatives. Information documents, including guidance on what to do after the death of a relative or friend and how to contact local bereavement support groups were available within the home.

Areas for Improvement

No areas for improvements are identified at this time. The home is commended for their management of end of life care.

Number of Requirements:	0	Number of Recommendations:	0

5.5 Additional Areas Examined

5.5.1 Provision of Snacks

The serving of the afternoon tea break for patients was observed. Plain biscuits were observed on the trolley and there was no choice of food at this time being offered to patients. Several patients who required a specialist diet were observed being offered fluids only. Discussion with two care assistants confirmed that patients who required their food to be of a pureed consistency were not always offered food during the afternoon tea break. This practice is not in keeping with the "Nutritional guidelines and menu checklist for Residential and Nursing Homes" 2014. The registered manager gave assurances during feedback that this issue would be addressed immediately following the inspection. A recommendation has been made.

5.5.2 Infection Prevention and Control

During a tour of the environment a substantial amount of toiletries, handling aids, incontinence products and various other items were observed to be stored in several bathrooms. This practice is not in keeping with infection prevention and control guidance. The registered manager gave assurances during feedback that this issue would be addressed immediately following the inspection. A requirement has been made.

5.5.3 Consultation with patients, their representatives, staff and a visiting professional

Part of the methodology in collecting data for the inspection process included speaking with staff, patients and patient's relatives, asking them to give their own personal views on their impression of Silverdale. Questionnaires were also given out for completion to aid data collection. Three staff, two relatives/representatives and five patients returned the questionnaires on the day of the inspection. One questionnaire given out during the inspection and was received by RQIA after the inspection. As discussed previously the issues identified were discussed with the registered person after the inspection.

A number of patients' comments are detailed below:

'It is great living here'
'I can't complain about a thing'
'You get everything you want here'
'The staff treat me well …I like living in Silverdale'
'Home from home'
'Everyone is very good to me here'

A number of comments were received from relatives and are detailed below:

'It is a homely place'
'It is dead on here, very good care'
'The nursing staff are very helpful'
'Great place…they always aim to please'

Review of staff questionnaires received indicated that staff took pride in delivering safe, effective and compassionate care.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Geraldine Browne, registered manager and Ms Val Humphreys, nursing sister as part of the inspection process. The timescales for completion commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person/manager to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Care Standards for Nursing Homes, April 2015. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan

Statutory Requirements	
Requirement 1 **Ref:** Regulation 13 (7) **Stated:** First time **To be Completed by:** Immediate from the date of inspection	The registered person must ensure the storage of items in the bathrooms is managed in accordance with infection prevention and control guidance. **Response by Registered Person(s) Detailing the Actions Taken:** All bathrooms have been decluttered with all storage boxes removed to prevent inappropriate storage in these areas. All staff reminded of importance of Infection prevention and control guidance.
Recommendations	
Recommendation 1 **Ref:** Standard 12.1 **Stated:** First time **To be Completed by:** Immediate from the date of inspection	The registered person should review the menu choice and the serving of snacks for all patients, including those who require a specialised diet, in accordance with the 'Nutritional guidelines and menu checklist for residential and nursing homes' 2014. **Response by Registered Person(s) Detailing the Actions Taken:** The head cook has reviewed the menu choice to ensure that those patients who require a specialised diet due to dysphagia, can avail of an appropriate snack at afternoon tea time.

Registered Manager Completing QIP	Mrs Geraldine Browne	**Date Completed**	03/08/15
Registered Person Approving QIP	Mrs Roberta Brownlee	**Date Approved**	04/08/15
RQIA Inspector Assessing Response	Mrs Norma Munn	**Date Approved**	05/08/15

Please ensure the QIP is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address