

# Inspection Report

30 April 2024



## Silverdale

Type of service: Nursing

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Assurance, Challenge and Improvement in Health and Social Care

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## 1.0 Service information

<b>Organisation/Registered Provider:</b> SRG Care Limited  <b>Registered Person:</b> Mrs Sarah Roberta Brownlee	<b>Registered Manager:</b> Mrs Geraldine Browne  <b>Date registered:</b> 10 June 2009
<b>Person in charge at the time of inspection:</b> Mrs Geraldine Browne	<b>Number of registered places:</b> 41  A maximum of 14 patients in category NH-DE, 1 bedroom in NH-I category only to be used by ambulant persons. The home is also approved to provide care on a day basis for 4 persons
<b>Categories of care:</b> Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia PH – Physical disability other than sensory impairment.	<b>Number of patients accommodated in the nursing home on the day of this inspection:</b> 39
<b>Brief description of the accommodation/how the service operates:</b> This home is a registered Nursing Home which provides nursing care for up to 41 patients. The home is divided into two units.	

## 2.0 Inspection summary

This unannounced inspection took place on 30 April 2024, from 9.35am to 3pm. The inspection was conducted by a care inspector.

The inspection assessed progress with the one area of improvement identified in the home 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.

Patients praised the care in the home and the kindness and support received from staff.

Staff spoke positively on their views on the provision of care, staffing, training, teamwork and managerial support.

There was a nice ambience and atmosphere in the home and care was seen to be delivered in a compassionate manner.

No areas requiring improvement were identified during this inspection.

RQIA were assured that the delivery of care and service provided in Silverdale was safe, effective, compassionate and that the home was well led.

### **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 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 was observed and how staff went about their work.

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

The findings of the inspection were discussed with Mrs Geraldine Browne at the conclusion of the inspection.

### **4.0 What people told us about the service**

Patients said that they felt well cared for and that staff were kind and attentive. Patients who were unable to articulate their views were seen to be comfortable, content and at ease in their environment and interactions with staff. Two patients made the following statements; "They're (the staff) the best here." and "All is very good. No problems."

Staff spoke in positive terms about their roles and duties, saying that they felt the standard of care provided for was very good. Staff said the workload was busy but manageable, that there was good morale, team working, training and managerial support.

One visiting relative said that the home was very good and they were kept well informed of any changes in the loved one's care and well-being.

## 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 16 May 2023		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
<b>Area for improvement 1</b>  Ref: Regulation 24(4)  Stated: First time	The registered person must ensure all complaints are documented clearly in the record of complaints.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> This record has been reviewed accordingly.	

## 5.2 Inspection findings

### 5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. A review of two staff members' recruitment records confirmed there was a robust system in place to ensure staff were recruited correctly to protect patients.

The staff duty rota accurately reflected the staff working in the home on a daily basis. The duty rota identified the nurse in charge when the Manager was not on duty. Any nurse who has responsibility of being in charge of the home in the absence of the Manager has a competency and capability assessment in place.

Staff registrations with the Nursing & Midwifery Council (NMC) or the Northern Ireland Social Care Council (NISCC) were audited on a monthly basis. A review of these audits found these to be appropriately maintained.

A scheduled of staff supervision and appraisal was in place.

Staff said there was good team work and that they felt well supported in their role, were satisfied with communication between staff and management and they worked well as a team. The Manager explained how the number of staff on duty was regularly reviewed 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; and to provide patients with a choice on how they wished to spend their day.

There were systems in place to ensure staff were trained and supported to do their job. Staff mandatory training was maintained on an up-to-date basis. Staff spoke positively on their training and how it was provided. One nurse described how their attendance at a recent course and helped improve their practice and established quality initiatives in the home.

### 5.2.2 Care Delivery and Record Keeping

Staff interactions with patients were observed to be polite, friendly and warm. It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering. Expressions of consent were evident with statements such as "Are you okay with..." or "Would you like to ..." when dealing with care delivery. Staff showed understanding and sensitivity to patients' needs.

Care records were maintained which reflected the needs of the patients.

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 included any advice or recommendations made by other healthcare professionals.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. The food was attractively presented and portions were generous. There was a variety of drinks available. During the dining experience, staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed. One patient said; "The food is very good. Always well prepared."

There was evidence that patients' weights were checked at least monthly to monitor weight loss or gain. Records were kept of what patients had to eat and drink daily. Patients who had specialist diets as prescribed by the Speech and Language Therapist (SALT) had care plans in place which were in accordance with their SALT assessment. Staff had received training in dysphasia.

Patients who are less able to mobilise require special attention to their skin care. These patients were assisted by staff to change their position regularly. Care records reflected the patients' needs and if required nursing staff consulted the Tissue Viability Specialist Nurse (TVN) and followed the recommendations they made.

At times some patients may be required to use equipment that can be considered to be restrictive. For example, alarm mats and bed rails. It was established that safe systems were in place to manage this aspect of care.

Examination of records and discussion with staff confirmed that the risk of falling and falls were suitably managed. There was evidence of appropriate onward referral as a result of the post falls review.

Daily progress records were kept of how each patient spent their day and the care and support provided by staff. Any issues of assessed need had a recorded statement of care / treatment given with effect of same recorded. The outcomes of visits from any healthcare professional were also recorded.

Care records were held confidentially.

One visiting professional had sent a complimentary letter saying how they were very impressed by the professionalism of the nursing staff.

### 5.2.3 Management of the Environment and Infection Prevention and Control

The home was clean, tidy and fresh smelling throughout, with a good standard of décor and furnishings being maintained. Patients' bedrooms were personalised with items important to the patient. Communal areas were suitably furnished and comfortable. Bathrooms and toilets were clean and hygienic.

Cleaning chemicals were stored safely and securely.

The grounds of the home were suitably maintained.

All staff were in receipt of up-to-date training in fire safety. Fire safety records were appropriately maintained with up-to-date fire safety checks of the environment and fire safety drills.

The home's most recent fire safety risk assessment dated 9 January 2024 had no recommendations made as a result of it.

Fire safety exits were free from obstruction.

Review of records, observation of practice and discussion with staff confirmed that effective training on infection prevention and control measures and the use of PPE had been provided. Staff were also seen to adhere to correct IPC protocols.

### 5.2.4 Quality of Life for Patients

Patients said that they were happy with their life in the home, and the care and that staff were kind and attentive. Two patients made the following comments; "It's very good here. The staff are very friendly." and "It's a peaceful home here."

Patients were dressed well and their aids and appliances were clean.

Observations of care practices confirmed that patients were able to choose how they spent their day. The genre of music and television channels played were in keeping with patients' age group and tastes.

It was also observed that staff offered choices to patients throughout the day which included preferences for food and drink options.

The atmosphere in the home was relaxed with patients seen to be comfortable, content and at ease in their environment and interactions with staff.

A planned programme of activities was in place for which patients were seen to gained enjoyment from.

### 5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection. Mrs. Geraldine Browne, is the registered manager of the home. Staff spoke positively about the managerial arrangements in the home, saying there was good support and availability.

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 Manager was identified as the appointed safeguarding champion for the home. It was established that good systems and processes were in place to manage the safeguarding and protection of vulnerable adults. The safeguarding policy was up-to-date and in accordance with legislation. Discussions with staff confirmed knowledge and understanding of the safeguarding policy and procedure. Staff also said that they felt confident about raising any issues of concern to management and felt these would be addressed appropriately.

It was established that the manager had a system in place to monitor accidents and incident that happened in the home. Accidents and incidents were notified, if required, to the patient's next of kin and their aligned named worker.

Discussions with the manager confirmed that expressions of dissatisfaction were taken serious and managed appropriately.

There was a system of audits and quality assurance in place. These audits were maintained on an up-to-date basis and included audits of; positioning and skin integrity, wound care and infection prevention and control.

The home was visited on numerous occasions each month by the responsible individual 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 good detail, with action plans in place for any issues identified. These reports are available for review by patients, their representatives, the Trust and RQIA.

### 6.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Geraldine Browne, Registered Manager, as part of the inspection process and can be found in the main body of the report.



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