Announced Primary Inspection

Name of Establishment:	**Silverdale Private Nursing Home**
Establishment ID No:	**1211**
Date of Inspection:	**09 June 2014**
Inspector's Name:	**Heather Moore**
Inspection No:	**16498**

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
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1.0 General Information

Name of Home:	Silverdale Private Nursing Home
Address:	29a Castlegore Road Castlederg BT81 7RU
Telephone Number:	028 8167 9574
E mail Address:	silverdalenh@btconnect.com
Registered Organisation/ Registered Provider:	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
Registered Categories of Care and number of places:	NH-DE NH-I NH-PH Day care – Four Persons
Number of Patients Accommodated on Day of Inspection:	40 (1 patient in hospital on day of inspection)
Date and time of this inspection: **Scale of Charges(per week)**	09 June 2014: 08.30 hours -16.30 hours £581.00 - £624.00
Date and type of previous inspection:	20 May 2013 Primary Announced

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect nursing homes. A minimum of two inspections per year is required.

This is a report of a primary announced inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection were met.

3.0 Purpose of the Inspection

The purpose of this inspection was to consider whether the service provided to patients was in accordance with their assessed needs and preferences and was in compliance with legislative requirements, minimum standards and other good practice indicators. This was achieved through a process of analysis and evaluation of available evidence.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

The aims of the inspection were to examine the policies, practices and monitoring arrangements for the provision of nursing homes, and to determine the provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008)

Other published standards which guide best practice may also be referenced during the Inspection process.

4.0 Methods/Process

Committed to a culture of learning, the RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the DHSSPS Nursing Homes Minimum Standards 2008.

The inspection process has three key parts; self-assessment (including completion of self -declaration), pre-inspection analysis and the inspection visit by the inspector.

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

- analysis of pre-inspection information
- discussion with the registered provider
- discussion with the registered manager

- examination of records
- consultation with stakeholders
- tour of the premises
- evaluation and feedback.

Any other information received by RQIA about this registered provider has also been considered by the inspector in preparing for this inspection.

5.0 Consultation Process

During the course of the inspection, the inspector spoke with:

Patients	**10 individually and with others in groups**
Staff	**12**
Relatives	**3**
Visiting Professionals	**1**

Questionnaires were provided, during the inspection, to patients, their representatives and staff to seek their views regarding the service. Matters raised from the questionnaires were addressed by the inspector in the course of this inspection.

Issued To	**Number issued**	**Number returned**
Patients	**6**	**6**
Relatives / Representatives	**2**	**2**
Staff	**10**	**10**

6.0 Inspection Focus

The inspection sought to establish the level of compliance achieved regarding the selected DHSSPS Nursing Homes Minimum Standards.

The criteria from the following standards are included;

- Management of Nursing Care – Standard 5
- Management of Wounds and Pressure Ulcers –Standard 11
- Management of Nutritional Needs and Weight Loss – Standard 8 and 12
- Management of Dehydration – Standard 12

An assessment on the progress of the issues raised during and since the previous inspection was also undertaken.

The inspector will also undertake an overarching view of the management of patient's human rights to ensure that patients' individual and human rights are safeguarded and actively promoted within the context of services delivered by the home.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance statements		
Guidance - Compliance statements	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

7.0 Profile of Service

Silverdale Private Nursing Home is conveniently located in its own beautifully landscaped grounds on the outskirts of the village of Castlederg, Co. Tyrone and provides care for up to 41 patients.

The home is registered in the following categories of care:

Nursing Care

NH-I – Old age not falling within any other category
NH-DE – Dementia
NH-I, NH-PH – Physical disability other than sensory impairment

The home is also registered to provide day care for four persons.

The home consists of two units:

The general nursing unit is a single storey accommodation which comprises of one double room with en-suite facilities and 25 single rooms, two of which have en-suite facilities, a main kitchen, dining room, designated smoking area, two sitting areas, two conservatories, staff accommodation, offices, bathrooms, toilet and shower facilities and storage space.

The dementia unit is a two storey accommodation with access to the first floor via a through floor lift and stairs and comprises of 14 single bedrooms, two of which have en-suite facilities, a day room, a quiet room, bathroom, toilet and shower facilities and storage space.

The certificate of registration issued by the Regulation and Quality Improvement Authority (RQIA) accurately reflected the categories of care and was appropriately displayed in a prominent position of the home.

8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary inspection (announced) to Silverdale Private Nursing Home. The inspection was undertaken by Heather Moore on 09 June 2014 from 08.30 hours to 16.30 hours.

The inspector was welcomed into the home by Mrs Geraldine Browne Registered Manager who was available throughout the inspection Mrs Roberta Brownlee Registered Provider was also available in the afternoon of the inspection. Verbal feedback of the issues identified during the inspection was given to the registered provider and to the registered manager at the conclusion of the inspection.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one.

During the course of the inspection, the inspector met with patients, staff and three relatives. The inspector observed care practices, examined a selection of records and carried out a general inspection of the nursing home environment as part of the inspection process.

Questionnaires were issued to patients, staff and two relatives during the inspection.

The inspector spent a number of extended periods observing staff and patient interaction. Discussions and questionnaires are unlikely to capture the true experiences of those patients unable to verbally express their opinions. Observation therefore is a practical and proven method that can help us to build up a picture of their care experience.

These observations have been recorded using the Quality of Interaction Schedule (QUIS). This tool is designed to help evaluate the type and quality of communication which takes place in the nursing home. A description of the coding categories of the Quality of Interaction Tool is appended to the report at appendix two.

As a result of the previous inspection conducted on 20 May 2013, one requirement and four recommendations were issued. This requirement and recommendations were reviewed during this inspection. The inspector evidenced that the requirement and recommendations had been fully complied with. Details can be viewed in the section immediately following this summary.

Standards inspected:

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed. (Selected criteria)

Standard 8: Nutritional needs of patients are met. (Selected criteria)
Standard 11: Prevention and treatment of pressure ulcers. (Selected criteria)

Standard 12: Patients receive a nutritious and varied diet in appropriate surroundings at times convenient to them. (Selected criteria)

Inspection Findings:

- **Management of Nursing Care – Standard 5**

The inspector can confirm that at the time of the inspection there was evidence to validate that patients receive safe and effective care in Silverdale.

There was evidence of comprehensive and detailed assessment of patient needs from date of admission. This assessment was found to be updated on a regular basis and as required. A variety of risk assessments were also used to supplement the general assessment tool. The assessment of patient needs was evidenced to inform the care planning process.

Comprehensive reviews of the assessments of need, the risk assessments and the care plans were maintained on a regular basis plus as required.

There was also evidence that the referring HSC Trust maintained appropriate reviews of the patient's satisfaction with the placement in the home and the quality of care delivered.

- **Management of Wounds and Pressure Ulcers –Standard 11**

The inspector evidenced that wound management in the home was well maintained. There was evidence of appropriate assessment of risk of development of pressure ulcers which demonstrated timely referral to Tissue Viability professionals for guidance and pressure relieving equipment. Care plans for the management of risks of pressure ulcers and wound care were maintained to a professional standard. A recommendation is made in regard to the maintenance of patients' repositioning charts.

A requirement is also made that care assistants receive training in pressure area care and prevention.

- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12**

The inspector reviewed the management of nutrition and weight loss within the home.

Robust systems were evidenced with risk assessments and appropriate referrals to GP's, speech and language therapists and or dieticians being made as required. The inspector also observed the serving of the lunch meal and can confirm that the patients were offered a choice of meal and that the meal service was well delivered. Patients were observed to be assisted with dignity and respect throughout the meal.

- **Management of Dehydration – Standard 12**

The inspector also examined the management of dehydration during the inspection. The home was evidenced to identify fluid requirements for patients and records were maintained of the fluid intake of those patients assessed at risk of dehydration.

Inspection of a sample of patients fluid balance charts revealed that these were recorded appropriately however a recommendation is made to record the patients daily fluid targets in the patients care plans on eating and drinking.

Patients' fluid intake for each 24 hour period should also be recorded in the evaluation of care and treatment provided to patients.

A requirement is also made that registered nurses receive training in Enteral feeding systems.

Patients were observed to be able to access fluids with ease throughout the inspection.

The inspector can confirm that based on the evidence reviewed, presented and observed; that the level of compliance with this standard was assessed as compliant.

Patients / their representatives and staff questionnaires

Some comments received from patients

- "I think Silverdale is a happy and safe place to be in."
- "All the staff are very pleasant."
- "I am always offered a choice of food and drink."
- "I am now here 18 months I really feel at home here and I enjoy the staff. They are all so good and caring."
- "I feel that we are all very well looked after, listened to in many ways."
- "It is a home from home". I am still fit enough to go out on family occasions but I am really content and happy to come back. This must say it all."

Some comments received from representatives

- "Quality care here, it is excellent."
- "I am always made welcome my relative is well looked after."
- "Staff are also good the home has adequate social events e.g. singing games and quizzes."
- "I am very happy with the standard of care here."
- "The staff here are all so good."

Professional's comments

One visiting professional took the opportunity to speak to the Inspector and spoke highly of the standard of care being provided in the home.

Some comments from staff

- "I think this is a great home, I am very happy here."
- "I love my work there is great teamwork and problems are solved promptly."
- "I have been here for 20 years and I feel this is a fantastic care home, the patients are given a very high standard of care."

- "They have activities here every day it very good."
- "This is a very happy environment to work in."
- "Silverdale provides quality care in a homely setting that ensures all the residents enjoy a happy life."

A number of additional areas were also examined

- Records required to be held in the nursing home
- Guardianship
- Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS)
- Patient and staff quality of interactions (QUIS)
- Complaints
- Patient finance pre-inspection questionnaire
- NMC declaration
- Staffing and staff comments
- Comments from representatives/relatives *and visiting professionals*
- Environment.

Full details of the findings of inspection are contained in section 11 of the report.

Conclusion

The inspector can confirm that at the time of inspection the delivery of care to patients was evidenced to be of a good standard. There were processes in place to ensure the effective management of the themes inspected.

The home's general environment was maintained to a high standard, and patients were observed to be treated with dignity and respect.

However areas for improvement are identified. One requirement and two recommendations are made. This requirement and recommendations are addressed throughout the report and in the Quality Improvement plan (QIP).

The inspector would like to thank the patients, registered provider, registered manager, registered nurses, relatives and staff for their assistance and co-operation throughout the inspection process.

The inspector would also like to thank the patients, relatives and staff who completed questionnaires.

9.0 Follow-up on Previous Issues

No	Regulation Ref.	Requirement	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	16 (2) (b)	The registered person shall ensure that the identified patient's risk assessment is reviewed and updated appropriately.	Inspection of three patients care records confirmed that the patients' risk assessments were reviewed and updated.	**Compliant**

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	5.3 Standard 5	It is recommended that the care plans are reviewed and updated to specify the pressure relieving equipment in place on the patients bed and also when sitting out of bed.	Inspection of three patients care records confirmed that the pressure relieving equipment in place on the patient's bed and also when sitting out of bed was recorded appropriately.	**Compliant**
2	25.12 Theme 1	It is recommended that a policy and procedure is developed to outline the purpose, content and process of the Regulation 29 unannounced visits.	Inspection of the home's policies and procedures confirmed that a policy and procedure was developed to outline the purpose, content and process of the Regulation 29 unannounced visits.	**Compliant**
3	5.3 Standard 5	It is recommended that wound management is included in registered nurses competency and capability assessments.	Inspection of three registered nurses competency and capability assessments confirmed that wound management was included.	**Compliant**
4	5.3 Standard 5	It is recommended that pressure area care and prevention is included in the template used to undertake care induction programmes.	Inspection of the template used to undertake care induction programmes confirmed that pressure area care was included.	**Compliant**

10.0 Inspection Findings

Section A

Standard : 5.1

- **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment**

Standard 5.2

- **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission**

Standard 8.1

- **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent**

Standard 11.1

- **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.**

Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

- **Management of Wounds and Pressure Ulcers –Standard 11**
- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12**
- **Management of Dehydration – Standard 12**

Inspection Findings:

Policies and procedures relating to pre-admission and admission for planned and emergency admissions were available in the home. Review of these policies evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing

Homes Minimum Standards (2008) and NMC professional guidance.

There was evidence to demonstrate that patients' individual needs were established on the day they were admitted to the nursing home, and effective procedures were in place to manage any identified risks.

The inspector reviewed three patients' care records which evidenced that at the time of each patient's admission to the home, a registered nurse carried out initial risk assessments and developed agreed plans of care to meet the patient's immediate care needs.

Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, pain and continence were also completed on admission.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

Section B

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

- **Management of Wounds and Pressure Ulcers –Standard 11**
- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12**
- **Management of Dehydration – Standard 12**

Standard 5.3

- **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.**

Standard 11.2

- **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.**

Standard 11.3

- **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.**

Standard 11.8

- **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration**

Standard 8.3

- **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.**

Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16
Inspection Findings:
The inspector observed that a named nurse system was operational in the home. Review of three patients' care records and discussion with ten patients individually and three patient's representative evidenced that patients and/or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. Records also evidenced discussion with patients and/or their representatives following changes to the plans of care. In relation to wound care, the inspector examined two patients' care records. Body mapping charts were completed for patients on admission. These charts were reviewed and updated when any changes occurred to the patients' skin conditions. Care plans were in place which specified the pressure relieving equipment in place on the patients' beds and also when sitting out of bed. There was evidence that patients' had pressure relieving devices in place, and the type of mattress in use was based on the outcome of the pressure risk assessment. A daily repositioning and skin inspection chart was in place for patients with wounds and or at risk of pressure damage. A review of two repositioning charts revealed that patients' skin was inspected for evidence of change, patients were assessed at every positional change and a record of the findings was maintained. However two patients' record confirmed a shortfall in recording practices. A recommendation is made in this regard. Patients' moving and handling needs were assessed and addressed in their care plans. There was evidence that manual handling aids were used to minimise risk of friction. Staff consulted confirmed there was sufficient nursing equipment available to move and handle patients' appropriately. Wound observation charts outlined the dimensions of wounds and were completed each time dressings were changed. Entries were also made in wound care records each time the dressings were changed. Care plans based on the outcome of a pain assessment was drawn up for patients. Discussion with two registered nurses and review of three patients' care records confirmed that where a patient was assessed as being 'at

risk' of developing a pressure ulcer, a care plan was in place to manage the prevention plan and treatment programme. Advice sought from the relevant healthcare professionals was recorded. Care records reflected advice provided by these professionals, and records reviewed demonstrated that the advice provided was adhered to.

The registered manager confirmed that there were referral procedures in place to obtain advice and guidance from tissue viability nurses in the local healthcare trust. Staff spoken with was knowledgeable regarding the referral process. Discussion with two registered nurses evidenced that they were knowledgeable of the action to take to meet the patients' needs in the interim period while waiting for the relevant healthcare professional to assess the patient.

Review of the records of incidents revealed that the incidence of pressure ulcers, grade 2 and above was reported to the RQIA in accordance with Regulation 30 of the Nursing Home Regulations (Northern Ireland) 2005.

Patients' weights were recorded on admission and on at least a monthly basis or more often if required.

Patients' nutritional status was also reviewed on at least a monthly basis or more often if required.

Daily records were maintained regarding patients' daily food and fluid intake. However a recommendation is made that the patients daily fluid targets are recorded in the patients care plans on eating and drinking. The patients' daily fluid intake over the 24 hour period should also be recorded in the daily evaluation of care and treatment.

Policies and procedures were in place for staff on making referrals to the dietician. These include indicators of the action to be taken and by whom.

All nursing staff spoken with were knowledgeable regarding the referral criteria for a dietetic assessment.

Care records reviewed evidenced that patients were referred for dietetic assessment in a timely manner.

Observation of practice and discussion with patients and staff evidenced that the nutritional care plans were being implemented.

Review of staff training records revealed that registered nurses had received training in wound management on5 June 2014; care assistants had not received training in pressure area care and prevention. A requirement is made in this regard.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially Compliant**

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Section C

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

- **Management of Wounds and Pressure Ulcers –Standard 11**
- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12**
- **Management of Dehydration – Standard 12**

Standard 5.4

- **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.**

Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16

Inspection Findings:

Review of three patients' care records revealed that re-assessment was an on-going process and was carried out daily or more often in accordance with the patients' needs. Day and night registered nursing staff recorded evaluations in the daily progress notes on the delivery of care including wound management for each patient.

Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required.

Review of two patients' care records in relation to wound care and management of nutrition indicated that they were reviewed at least weekly.

The evaluation process included the effectiveness of any prescribed treatments, for example prescribed analgesia.

Discussion with the registered manager and review of governance documents evidenced that the quality of care records was audited on a monthly basis. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

Section D

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

- **Management of Wounds and Pressure Ulcers –Standard 11**
- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12**
- **Management of Dehydration – Standard 12**

Standard 5.5

- **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.**

Standard 11.4

- **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.**

Standard 8.4

- **There are up to date nutritional guidelines that are in use by staff on a daily basis.**

Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)

Inspection Findings:

The inspector examined three patients' care records which evidenced the completion of validated assessment tools such as;

- The Roper, Logan and Tierney assessment of activities of daily living
- Braden pressure risk assessment tool
- Nutritional risk assessment such as Malnutrition Universal Screening Tool (MUST).

The inspector confirmed the following research and guidance documents were available in the home;

- The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes for Older People
- The National Institute for Health and Clinical Excellence (NICE) for the management of pressure ulcers in primary and secondary care
- The European Pressure Ulcer Advisory Panel (EPUAP).

Discussion with the registered manager and registered nurses confirmed that they had a good awareness of these guidelines. Review of four patients' care records evidenced that registered nurses implemented and applied this knowledge.

Discussion with the registered manager and review of governance documents evidenced that the quality of pressure ulcer/wound management was audited on a monthly basis. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process.

Staff spoken with were knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care. Two registered nurses and two care staff consulted could identify patients who required support with eating and drinking.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

Section E

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

- **Management of Wounds and Pressure Ulcers –Standard 11**
- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12**
- **Management of Dehydration – Standard 12**

Standard 5.6

- **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.**

Standard 12.11

- **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.**

Standard 12.12

- **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.**
  Where a patient is eating excessively, a similar record is kept
  All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25

Inspection Findings:

A policy and procedure relating to record management was available in the home. Review of these policies evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Home Minimum Standards (2008) and NMC professional guidance.

Registered nurses spoken with were aware of their accountability and responsibility regarding record keeping.

A review of the training records confirmed that staff had received training on the importance of record keeping commensurate with their roles and responsibilities in the home.

Review of three patients' care records evidenced/confirmed that registered nursing staff on day and night duty recorded statements to reflect the care and treatment provided to each patient.

These statements reflected wound and nutritional management intervention for patients if required.

Additional entries were made throughout the registered nurses span of duty to reflect changes in care delivery, the patient's status or to indicate communication with others concerning the patient.

Entries were noted to be dated, timed and signed with the signature accompanied by the designation of the signatory.

The inspector reviewed a record of the meals provided for patients. Records were maintained in sufficient detail which enabled the inspector to judge that the diet for each patient was satisfactory. For example, the record evidenced a choice at each mealtime.

The inspector reviewed the care records of two identified patients of being at risk of inadequate food and fluid intake. This review confirmed that;

- Daily records of food and fluid intake were being maintained
- The nurse in charge had discussed with the patient/representative regarding their dietary needs
- Where necessary a referral had been made to the dietician and or the speech and language therapist
- Care plans had been devised to manage needs and were reviewed regularly, monthly or more often if deemed appropriate
- Care plans were reflective of recommendations made by specialist healthcare professionals.

Staff spoken with were knowledgeable regarding patients' nutritional needs.

Discussion with the registered manager and review of governance documents evidenced that the quality of record management was in keeping with DHSSPS minimum standards and NMC guidelines.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

Section F

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed. **The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:** • **Management of Wounds and Pressure Ulcers –Standard 11** • **Management of Nutritional Needs and Weight Loss – Standard 8 and 12** • **Management of Dehydration – Standard 12**
Standard 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**
Inspection Findings:
Please refer to criterion examined in section E. In addition the review of patients' care records evidenced that consultation with the patients and/or their representatives had taken place in relation to the planning of their care. This is in keeping with the DHSSPS minimum standards and the Human Rights Act 1998.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

Section G

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

- **Management of Wounds and Pressure Ulcers –Standard 11**
- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12**
- **Management of Dehydration – Standard 12**

Standard 5.8

- **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate**

Standard 5.9

- **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.**

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)

Inspection Findings:

Prior to the inspection a patients' care review questionnaire was forwarded to the home for completion by staff. The information provided in this questionnaire revealed that all of the patients in the home had a care review undertaken through care management arrangements between 01 April 2013 and 31 March 2014.

The registered manager informed the inspector that care management reviews were held post admission and then annually thereafter. Reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the patient or family. A member of nursing staff attends each review. A copy of the minutes of the most recent review was held in the patient's care record file.

The inspector viewed the minutes of three care management reviews which evidenced that, where appropriate patients and their representatives had been invited to attend. Minutes of the review included the names of those who had attended an assessment of the

patients' needs and a record of issues discussed. Care plans were updated to reflect recommendations made at care management reviews where applicable.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

Section H

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.

Criterion 12.1

- **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.**
  Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.

Criterion 12.3

- **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.**
  A choice is also offered to those on therapeutic or specific diets.

Nursing Homes Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)

Inspection Findings:

A policy and procedure was in place to guide and inform staff in regard to nutrition and dietary intake. The policy and procedure in place was reflective of best practice guidance.

There was a three weekly menu planner in place. The registered manager informed the inspector that the menu planner had been reviewed and updated in consultation with patients, their representatives and staff in the home. The current menu planner was implemented on 01 April 2014.

The inspector discussed with the registered manager and a number of staff the systems in place to identify and record the dietary needs, preferences and professional recommendations of individual patients.

Staff spoken with were knowledgeable regarding the individual dietary needs of patients to include their likes and dislikes. Discussion with staff and review of the record of the patient's meals confirmed that patients were offered choice prior to their meals.

Staff spoken with were knowledgeable regarding the indicators for onward referrals to the relevant professionals. e.g. speech and language

therapist or dieticians.

As previously stated under Section D relevant guidance documents were in place.

Review of the menu planner and records of patients' choices and discussion with a number of patients, registered nurses and care staff it was revealed that choices were available at each meal time. The registered manager confirmed choices were also available to patients who were on therapeutic diets.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

Section I

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Homes Regulations (Northern Ireland)2005:Regulation/s13 (1) and 20**
Inspection Findings:
The inspector discussed the needs of the patients with the registered manager. It was determined that a number of patients had swallowing difficulties. Review of staff training records revealed that staff had attended training in dysphagia awareness in May 2014. Inspection of training records also revealed that one registered nurse required to be updated in Enteral Feeding. A requirement is made in this regard.

Review of patients' care records who had been assessed by a speech and language therapist confirmed that their care plans had been reviewed to include the speech and language therapist's recommendations.

Discussion with registered manager confirmed that meals were served at appropriate intervals throughout the day and in keeping with best practice guidance contained within The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes.

The registered manager confirmed a choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements and choices were offered midmorning, afternoon and at supper times.

The inspector observed that a choice of fluids to include fresh drinking water were available and refreshed regularly. Staff were observed offering patients fluids at regular intervals throughout the day.

Staff spoken with were knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care. Two registered nurses and two care staff consulted could identify patients who required support with eating and drinking.

On the day of the inspection, the inspector observed the lunch meal. Observation confirmed that meals were served promptly and assistance required by patients was delivered in a timely manner.

Staff were observed preparing and seating the patients for their meal in a caring, sensitive and unhurried manner. Staff were also noted assisting patients with their meal and patients were offered a choice of fluids. The tables were well presented with condiments appropriate for the meal served.

A tissue viability link nurse was employed in the home.

Discussion with the registered nurses clearly evidenced their knowledge in the assessment, management and treatment of wounds. Review of the template used to undertake competency and capability assessments for the registered nurses revealed that pressure ulcer/wound care was addressed.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

11.0 Additional Areas Examined

11.1 Documents required to be held in the Nursing Home

Prior to the inspection a checklist of documents required to be held in the home under regulation 19(2) schedule 4 of The Nursing Homes Regulations (Northern Ireland) was forwarded to the home for completion. The evidence provided in the returned questionnaire confirmed that the required documents were maintained in the home and were available for inspection. The inspector reviewed the following records:

- The home's statement of purpose
- The patient's guide
- Sample of reports of unannounced visits to the home under regulation 29
- Sample of staff duty rosters
- Record of complaints
- Sample of incident/accidents
- Record of food provided for patients
- Statement of the procedure to be followed in the event of a fire
- Sample of the minutes of patients/relatives and staff meetings.

11.2 Patients under guardianship

Information regarding arrangements for any people who were subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) order 1986. At the time of the inspection, and living in or using this service was sought as part of this inspection. During the inspection there were no patients in the home who were subject to a guardianship order.

11.3 Human Rights Act 1998 and European Convention on Human Rights (ECHR) DNSSPS and Deprivation of Liberty Safeguards (DOLS)

The inspector discussed the Human Rights Act and the Human Rights Legislation with the registered manager. The inspector can confirm that copies of these documents were available in the home.

11.4 Quality of interaction schedule (QUIS)

The inspector undertook a number of periods of observation in the home which lasted approximately 20 minutes each.

The inspector observed the patients' lunch meal which was served in the dining room. The inspector also observed a small number of patients having their lunch meal in the day room. The observation tool used to record these observations uses a simple coding system to record interactions between staff, patients and visitors.

Positive interactions	All positive
Basic care interactions	
Neutral interactions	
Negative interactions	

A description of the coding categories of the Quality of Interaction Tool is appended to the report at appendix 2.

The staff were observed seating the patients in preparation for their lunch in an unhurried manner.

The staff explained to the patients their menu choice and provided adequate support and supervision.

Observation of care practices during these periods of observation revealed that staff were respectful in their interactions with the patients.

Overall the periods of observations were positive.

11.5 Complaints

Prior to the inspection a complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. The evidence provided in the returned questionnaire indicated that there were no complaints recorded since the previous inspection.

11.6 Patient Finance Questionnaire

Prior to the inspection a patient questionnaire was forwarded by RQIA to the home for completion. The evidence provided in the returned questionnaire indicated that patients' monies were being managed in accordance with legislation and best practice guidance.

11.7 NMC declaration

Prior to the inspection the manager was asked to complete a proforma to confirm that all nurses employed were registered with the Nursing and Midwifery Council of the United Kingdom (NMC).

The evidence provided in the returned proforma indicated that all nurses, including the manager were registered with the NMC.

11.8 Staffing /Staff Comments

On the day of inspection the inspector examined staff duty rosters for four weeks. Inspection confirmed that registered nurses and care staff staffing levels for day and night duty were in accordance with the RQIA's recommended minimum staffing guidelines.

The inspector spoke to 12 staff members during the inspection process and eight staff completed questionnaires.

Examples of staff comments were for as follows:

- "I think this is a great home, I am very happy here."
- "I love my work there is great teamwork and problems are solved promptly."

- “I have been here for 20 years and I feel this is a fantastic care home, the patients are given a very high standard of care.”
- “They have activities here every day it very good.”
- “This is a very happy environment to work in.”
- “Silverdale provides quality care in a homely setting that ensures all the residents enjoy a happy life.”

11.9 Patients’ Comments

The inspector spoke to six patients individually and with others in groups. Six patients completed questionnaires.

Examples of their comments were as follows

- “I think this is a great home, I am very happy here.”
- “I love my work there is great teamwork and problems are solved promptly.”
- “I have been here for 20 years and I feel this is a fantastic care home, the patients are given a very high standard of care.”
- “They have activities here every day it very good.”
- “This is a very happy environment to work in.”
- “Silverdale provides quality care in a homely setting that ensures all the residents enjoy a happy life.”

11.10 Relatives’ Comments

The inspector spoke to three relatives, two relatives completed a questionnaire.

An example of relatives comments are:

- “Quality care home, it is excellent.”
- “I am always made welcome my relative is well looked after.”
- “Staff are all so good there are adequate social events; for example singing, games, and quizzes.”
- The staff here are all so good.”

11.11 Professional’s Comments

One visiting professional took the opportunity to speak to the inspector and he spoke positively in regard the the standard of care being provided in the home.

11.12 Environment

The inspector undertook a tour of the home and viewed a number of patients’ bedrooms, communal facilities and toilet and bathroom areas.

The premises presented as warm, clean and comfortable with a friendly and relaxed ambience. The grounds around the home were beautifully maintained with a number of pots and hanging baskets with fresh flowers.

Seating areas were also provided.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed Mrs Roberta Brownlee, Registered Provider, Mrs Geraldine Browne, Registered Manager and Ms Val Dormer, Nursing Sister as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider / manager is required to record comments on the Quality Improvement Plan.

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.

Enquiries relating to this report should be addressed to:

Heather Moore
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Appendix One

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Standard 5.1 A pre admission assessment visit is carried out on all patients before they are admitted to Silverdale. The Care Manager from the Commissioning Trust provides a detailed nursing assessment for all patients prior to admission (CM5/NISAT). On the day of admission staff commence the completion of a comprehensive needs and risk assessment. The information obtained during the pre admission visit, the care management assessment and from the patient and their representative all inform the assessment and care planning process. A plan of care is implemented to meet the patients immediate care needs and over the next 72 hours staff continue to develop the care planning as they become more familiar with the patient's assessed needs, risks and preferences. On admission to the home staff assess the patient from head to toe and complete a body chart to depict any tissue viability concerns, bruises or	Compliant

marks. The following risk assessments are completed: Tissue Viability, Nutritional,(MUST) Moving and Handling, Falls Prevention, Braden Scale, Bristol Stool Chart and Continence Assessment. The findings from these assessments are reflected in the care plans and communicated to the relevant staff. There are procedures within the home to guide staff in the event of an emergency admission. 5.2 All patients have a comprehensive and holistic assessment of their needs completed within 11 days of admission. This assessment is completed in collaboration with the patient and their representative and takes into consideration the information provided by the care manager at the time of admission. 8.1 Our staff are fully aware of the importance of a good nutritional intake and of the risks and complications which may arise when a patient is unable to tolerate same. To ensure our patients receive appropriate nutritional care, we complete nutritional screening using (MUST) on each of our patients on admission and review monthly or more frequently depending on individual assessed needs. The findings from this nutritional screening directs the delivery of the individual patient's nutritional care plan and highlights the need to increase monitoring of dietary intake or the patient's weight and to refer to GP, Dietitian or other member of the Multi-Disciplinary team.. 11.1 Information provided by the referring care manager would in most circumstances inform the Registered Manager about the patient's assessed pressure ulcer risk or the presence of a pressure ulcer and the plan of care to manage same. This level of information will always be explored by the Registered Manager during the pre admission process. On admission to Silverdale the Braden Risk Assessment is completed on each patient and a plan of care is implemented to manage the level of risk as assessed. Clinical judgment is used when completing all patient assessments and when indicated advice is sought from the relevant members of the multi disciplinary team. The findings from the assessment and the plan of care are communicated to each member of the care team to ensure the delivery of care that is safe, effective and maintains the comfort of the patient.	

Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.3 A person centred approach is adopted to care planning which focuses on maximising the independence of each patient. The care plan is reflective of assessed needs, patients are enabled to take measured risks and the patient or their representative is involved in the care planning process. In conjunction with the multi disciplinary team, we have	Compliant

sucessfully rehabilitated many patients to enable them to return to their own home. Assessments and care plans are reviewed monthly by the named nurse to ensure they remain relevant and reflective of the needs of the patient. In order to meet the needs of our patients at all times we work collaboratively with the relevant members of the multi disciplinary team and frequently advocate in order to have their care and comfort maximised. All direction and guidance provided by our professional colleagues is acted upon, reflected in care plans and communicated to the relevant members of our team. 11.2 Silverdale has a tissue viability link nurse who has an overview of all tissue viability concerns within the home and is available to provide support and guidance to staff. We also have in place referral arrangements for seeking advice from the Trust's Tissue Viability Nurse, Dietitian, Speech and Language Therapist and Podiatrist. 11.3 On admission to Silverdale a Tissue Viability Risk Assessment is completed on each patient and reviewed monthly or more often if indicated. The patient's plan of care is based on the findings of this assessment, with the level of assessed risk being the determining factor in planning the patient's care. The plan of care will be written in collaboration with the patient and their representative and will be communicated to the relevant members of the multi disciplinary team. 11.8 Staff ensure that prompt referrals are made using appropriate referral arrangements and documentation, to the relevant specialists e.g. GP, Trust Tissue Viability Nurse, Podiatrist, Specialist Podiatrist or Vascular Surgeon, to obtain advice and support in the treatment and management of patients with lower limb or foot ulceration. Recommendations made by any of those Health Care Professionals is incorporated into the patient Care Plan documentation, implemented and evaluated on a regular time scale. 8.3 When a patient's condition or the outcome from nutritional screening gives rise for concern, a referral is made to the GP, dietitian or other health care professional, such as the speech and language therapist. All recommendations made by these health care professionals are incorporated in the patient's nutritional care plan, communicated to relevant staff and implemented. Nutritional care plans are kept under review and the resultant outcome for the patient monitored.	

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.4 Our staff carry out patient assessments on a daily basis and monitor their response to the care and treatment being delivered. We have a comprehensive staff handover at least twice each day, during which staff have the opportunity to discuss patients' general conditions and responses to care and treatment. Staff record an update on each patient's condition twice in 24 hours and conduct formal care plan and risk assessment reviews at least monthy or more frequently in response to the patient's condition.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.5 Care practices, activities and procedures within the home are all supported by good practice guidance and the most recent evidence base. We are very conscious of the importance of keeping our staff up to date with new initiatives and good practice guidance and invest substantially in ongoing training and development for our staff. Within the home we have our own link nurses who have a specialist interest and knowledge in specific areas of clinical practice. This provides an additional inhouse resource for the entire team and contributes to the delivery of safe, quality care for our patients. We also review practice in light of information received from publications and guidelines from DHSSPS, RQIA and others e.g. Bapen Nutritional Standards, Northern Ireland Regional Infection Control Manual, NICE and GAIN Guidlines. For example NICE Guidance on the prevention and management of pressure sores, GAIN Guidelines for the provision of domiciliary eyecare and Palliative and End of Life in nursing/residential care homes. The delivery of care to our patients with dementia is based on research conducted by the University of Sterling into the care of the patients with dementia. The design of the unit, the approach and skills of our staff have been developed	Compliant

through collaborative working with the Dementia Services Development Centre. Policies & Procedures are updated as needs indicate to reflect changes in the approach to a procedure or process. We also act on advice and alert notifications from the DHSSPS, HSCT and RQIA. 11.4 The European Pressure Ulcer Advisory Panel (EPUAP) grading tool is used to assess all incidents of skin damage and a plan of care and treatment is implemented in accordance with the grading and overall condition and presentation of the wound. The grading and prescribed plan of care is recorded in the patient's care plan and communicated to the relevant members of staff, to ensure continuity of care. 8.4 The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes for Older People (2014) are available for catering and care staff and account is taken of these guidelines when planning and reviewing the home's menu. In addition specific therapeutic diets as recommended by a dietitian or speech and language therapist are prepared for individual patients. Information is available within the home for patients and their representatives on specific diets and healthy eating. Staff are also very aware of the importance of providing fortified foods, and monitoring nutritional and fluid targets set for patients considered to be at nutritional risk.	

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.6 Each of the registered nurses employed at Silverdale are aware of the NMC guidelines for the completion of records and are aware of the importance of completing accurate, detailed and contemporaneous records, that are reflective of patients assessed needs and the care being delivered. Assessments and care plans are kept under review and amended as the patient's condition dictates. Care plans with specific goals are recorded to reflect the findings of assessments and records are maintained of the outcomes for patients. 12.11 and 12.12 Records are kept of all meals consumed or refused by an individual patient. These records are maintained by an allocated carer daily and reviewed by the registered nurse responsible for the patient. More detailed records of daily nutritional and fluid intake are maintained for those patients assessed as being at high nutritional risk. This enables the care team to closely monitor the patient and seek advice when necessary from the GP or relevant health care professional. Records of all such referrals are maintained	Compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.7 Staff in Silverdale are continously monitoring the condition of our patients and recording findings on at least a daily basis. In addition all risk assessments and care plans are evaluated at least monthly, or in response to a change in the patient's assessed needs or preferences. A record of the evaluations is recorded in the patient's care file. Changes to a patient's care plan are discussed with the patient and/or the patients representatives. Changes are also communicated to the relevant members of the team.	Compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.8 Staff are very aware of the importance of seeking and listening to the views of patients and daily they act upon these views promoting choice, independence and patient dignity where possible. Staff are also aware of the importance of measured risk to enable patients to maintain dignity and independence. The patient's primary nurse reviews all care plans at least monthly or more often as needs dictate and as far as possible involves the patient and/or their representative in this process. Care management reviews are carried out within 3 months of admission, repeated at 6 months then annually thereafter. We have good systems in place to monitor when Care Management Reviews are due. At time of reporting 100% have been fully completed and up to date. A care management review can be requested at any time by the patient or their representative or by a registered nurse employed in Silverdale. We endeavour at all times to have the patient and/or their representative present during formal care reviews, should this not be possible their comments and suggestions are sought in advance of the care review. The outcomes from all care reviews are reflected in care plans and communicated to the relevant members of staff for implementation. We have robust and timely care reviews conducted on each of our patients and the registered manager has in place a system to monitor both the timeliness of reviews and the outcomes from the	Compliant

reviews. 5.9 The care of each of our patients is constantly under review and all such reviews are recorded, dated and signed by a registered nurse. Patients and/or their representatives are kept informed of progress towards agreed goals particularly with respect to specific treatment such as nutritional concerns, wound care, infections or periods of rehabilitation. The minutes of all care reviews are available and signed by the following parties - care manager, registered nurse (Silverdale), patient and/or their representative. Outcomes from care reviews are communicated to staff and reflected in care records, care plans are updated accordingly. The minutes from all care reviews are retained in the patient's care file and are easily accessible to the members of the care team.	

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
12.1 All patients are provided with a nutritious and varied diet which meets their assessed needs and preferences and records are maintained and available to support this. The assessed needs and preferences of individual patients are communicated to care and catering staff and appropriate therapeutic diets such as pureed meals, fortified foods and diabetic diets are provided. Full account is taken of guidance documents and advice provided by dietitians and other health care professionals. Our menu is assessed against the menu checklist for residential and nursing homes. 12.3 The menu offers choice at each meal time to all patients including those who receive a therapeutic diet. If the choices provided on the pre planned menu are not acceptable to a patient on a given day then other alternatives are offered. As stated above, sadly some patients are unable to communicate their preferences and information provided by family members is important in assisting with menu selection. Staff also observe what meals patients enjoy and what meals they refuse and are reluctant to eat and this is taken into account on a daily basis. We place great importance on our head cook's consultation with patients and relatives the findings of which are analysed and displayed on the noticeboard in the dining room.	Compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
8.6 Staff in Silverdale are very familiar with each patient and any concerns which may indicate that an individual patient is experiencing swallowing difficulties such as frequent chest infections, coughing and choking at meal times, holding food in their mouth are referred to the speech and language therapist. All recommendations by the speech and language therapist are reinforced with the patient and/or their representative, communicated to relevant staff and recorded in the patient's care plan. Registered nurses or the speech and language therapist provide care staff with instruction on specific feeding techniques recommended for individual patients. Registered nurses are responsibile on a daily basis for ensuring all such instructions are followed.	Compliant

12.5 Meals times are promoted as an important social occasion for our patients with choice being offered at each meal time and served at times suited to patients individual needs. Meals are provided at the following times; Breakfast 7.00am – 10.00am, Mid Morning Refreshments 10.15- 11.00am, Mid Day Meal 12.30pm – 1.30pm, Afternoon Tea 2.30- 3.00pm, High Tea 5.00pm – 5.30pm and Supper 7.15pm onwards. Fresh water and juice is available in bedrooms and lounges these are replenishied at least twice per day. Fresh fruit is also readily available as is a variety of snacks and warm drinks throughout the day. We have "Weekly Special Days" and regular "Theme Days" which allow our patients to choose a meal of their choice outside the planned daily menu. All relatives are given a tray of tea/coffee or drinks whilst visiting. Many next of kin join their family member for lunch or high tea. 12.10 Silverdale Care Home has a "protected meal times" policy that is effective and monitored, this approach ensures that there are always adequate staff to assist and supervise where necessary. Assessed risks such as choking are managed in accordance with the patient's care plan. Individual dietary intake is monitored and assistance is always provided when required. Necessary aids and equipment are available for individual patient use. 11.7 We have at Silverdale one Link Tissue Viability Nurse who attends regular trainings and keeps themself developed professionally. They cascade their knowledge and skills through trainings to all nurses so each of our nurses has the necessary expertise and competence to carry out wound care within the home. Should a situation arise, for example a complex wound with a specialist treatment regime, we will seek training and support from the relevant Trust until we are satisfied that our staff are competent to carry out the procedure.	

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	**COMPLIANCE LEVEL**
	Compliant

Appendix Two

Explanation of coding categories as referenced in the Quality of Interaction Schedule (QUIS)

Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.	**Basic Care: (BC) –** basic physical care e.g. bathing or use if toilet etc. with task carried out adequately but without the elements of social psychological support as above. It is the conversation necessary to get the task done.
• Staff actively engage with people e.g. what sort of night did you have, how do you feel this morning etc. (even if the person is unable to respond verbally) • Checking with people to see how they are and if they need anything • Encouragement and comfort during care tasks (moving and handling, walking, bathing etc.) that is more than necessary to carry out a task • Offering choice and actively seeking engagement and participation with patients • Explanations and offering information are tailored to the individual, the language used easy to understand ,and non-verbal used were appropriate • Smiling, laughing together, personal touch and empathy • Offering more food/ asking if finished, going the extra mile • Taking an interest in the older patient as a person, rather than just another admission • Staff treat people with respect addressing older patients and visitors respectfully, providing timely assistance and giving an explanation if unable to do something right away • Staff respect older people's privacy and dignity by speaking quietly with older people about private matters and by not talking about an individual's care in front of others	**Examples include:** Brief verbal explanations and encouragement, but only that the necessary to carry out the task No general conversation

Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.	**Negative (NS) –** communication which is disregarding of the residents' dignity and respect.
Examples include: • Putting plate down without verbal or non-verbal contact • Undirected greeting or comments to the room in general • Makes someone feel ill at ease and uncomfortable • Lacks caring or empathy but not necessarily overtly rude • Completion of care tasks such as checking readings, filling in charts without any verbal or non-verbal contact • Telling someone what is going to happen without offering choice or the opportunity to ask questions • Not showing interest in what the patient or visitor is saying	**Examples include:** • Ignoring, undermining, use of childlike language, talking over an older person during conversations • Being told to wait for attention without explanation or comfort • Told to do something without discussion, explanation or help offered • Being told can't have something without good reason/ explanation • Treating an older person in a childlike or disapproving way • Not allowing an older person to use their abilities or make choices (even if said with 'kindness') • Seeking choice but then ignoring or over ruling it • Being angry with or scolding older patients • Being rude and unfriendly • Bedside hand over not including the patient

References

QUIS originally developed by Dean, Proudfoot and Lindesay (1993). The quality of interactions schedule (QUIS): development, reliability and use in the evaluation of two domus units. *International Journal of Geriatric Psychiatry* Vol *pp 819-826.

QUIS tool guidance adapted from Everybody Matters: Sustaining Dignity in Care. London City University.

Quality Improvement Plan

Announced Primary Inspection

Silverdale Private Nursing Home

09 June 2014

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with **Mrs Roberta Brownlee Registered Provider, Mrs Geraldine Browne Registered Manager and Ms Val Dormer Nursing Sister** either during or after the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers/managers should note that failure to comply with regulations may lead to further enforcement and/or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider/manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan 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.

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 (NI) 2005

No.	Regulation Reference	Requirement	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	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) **Ref Section B & I**	One	A training date for the 19/08/14 has been secured for all our Registered Nurses to update on Enteral Feeding Systems. A training programme for all Care Assistants to receive training on Pressure Area Care and Prevention has been commenced.	Two Months

Recommendations

These recommendations are based on the Nursing Homes Minimum Standards (2008), research or recognised sources. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	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. **Ref Section E**	One	Patients daily fluid targets and action to be implemented if these targets are not achieved are now recorded in patients Nutritional Care Plan. Each Patient on Fluid Balance Chart now have total fluid intake for each 24 hour period recorded in the Daily progresss records	One week
2	5.3	It is recommended that patients' repositioning charts are recorded appropriately. **Ref Section B**	One	All staff made aware of importance of accurate record keeping and patients repositioning charts will be recorded appropriately.	One week

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person:

Name of Registered Manager Completing Qip	MRS GERALDINE BROWNE
Name of Responsible Person / Identified Responsible Person Approving Qip	MRS ROBERTA BROWNLEE

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Heather Moore	11 August 2014
Further information requested from provider			