Inspection Report 2023-2024

Silverdale Care

Adult Care Home

13 July 2023

Isle of Man Government

DHSC

Under the Regulation of Care Act 2013 and Regulation of Care (Care Services) Regulations 2013

SECTION A Overall Summary

We carried out this inspection under Part 4 of the Regulation of Care Act 2013 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements, regulations and standards associated with the Act.

We carried out this unannounced inspection on 13 July 2023.

The inspection was carried out as part of a series of focussed inspections on services where we identified a number of unwitnessed falls or serious injuries over the last year.

The aim is to confirm if this is due to an increase in appropriate notification and/or an indication that actions need to be taken to improve the service in the area of falls.

In the cohort of older people the presence of multiple risk factors increases the likelihood of a fall or fracture. Research tell us that older people in care homes are three times more likely to fall than people of a similar age in the community, often these incidents are preventable. There are a number of approaches that can prevent some falls and fractures.

https://doi.org/10.1136/bmj-2021-066991

https://evidence.nihr.ac.uk/alert/falls-prevention-programme-effective-care-homes/

The inspection was led by a member of the Registration and Inspection team.

Service and service type
Silverdale Care is a nursing home based in Ballasalla. People in care homes receive support and accommodation as a single package under a contractual agreement. Silverdale is registered to accommodate sixty-three people across two floors.

People's experience of using this service and what we found
To get to the heart of people's experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Our key findings
Care plans and risk assessments contained up to date information and were reviewed after any fall / incident. The home's post falls management process was well documented in individual's care records.

When falls had taken place, new risk factors had been clearly identified as well as what action had been taken. There was evidence of timely involvement from and proactive referrals to other professionals and agencies.

Positive interactions were observed between people and members of staff. The manager knew the needs of the people in the home well.

Care records evidenced involvement from other professionals and agencies in response to a change of needs. Assistive technology, such as room sensors/sensor mats, were being used to support better outcomes for people.

Following any fall, information on the event was disseminated to the staff team through team meetings, handovers and internal emails. Silverdale was proactive in submitting notifications in accordance to statutory requirements.

SECTION B The Inspection

About the service
Silverdale Care is registered as an adult care home.

Registered manager status
The service has a registered manager. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of Inspection
This unannounced inspection was undertaken as part of a number of themed inspections where there were a concerning number of incidents notified to the Registration and Inspection team. The focus of this report was to review specific residents care files against the inspection framework.

We carried out an unannounced inspection on the 13 July 2023.

What we did before the inspection
We reviewed statutory notification of events forms from April 2022. We specifically concentrated on those notifications detailing unwitnessed falls or serious injuries during that period. Where there was a significant number of incidents, we analysed these in terms of frequency of falls for the same resident, actions taken by the home following the incident and any learning identified.

During the inspection
We examined the following evidence on inspection;

- A sample of electronic resident daily records
- Assessments and care plans relating to specific individuals
- Risk assessments relating to specific individuals
- Professional and other agency involvement

We also undertook a general walk around the home as part of the inspection.

After the inspection we discussed our findings with the manager.

SECTION C Inspection Findings

C1 Is the service safe?

Our findings:
Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. The service does not require any improvements in this area.

This service was found to be safe.

Initial assessments, care plans and risk assessments outlined people's choices and levels of independence.

We were assured that people were being kept safe from avoidable harm due to care plans and risk assessments containing up to date, accurate information in the small sample viewed. These were regularly reviewed and updated following any incident / accident.

There was evidence of the home actively trying to involve individuals or significant others in the review and risk assessment process. Family members were informed when an incident / accident occurred.

The home had a falls prevention and management policy which had been reviewed in August 2022. Staff were following the post fall management process and this was well documented on individual's daily notes. The manager said that falls management formed part of staff moving and handling training.

The majority of the falls notifications received by the Registration and Inspections team from the care home were unwitnessed falls that occurred inside people's rooms.

On the day of the inspection the premises were clean and hygienic and communal areas were uncluttered and free from hazards.

The manager said that the home was sufficiently staffed to meet people's needs. Currently there was one vacancy for a registered nurse. Silverdale was not running at full occupancy. For example, the home's Grosvenor Wing, offering 17 beds and catering for people with mental health issues, brain injury and dementia, had 11 residents living there. The manager said that she was deliberately keeping numbers down due to the current needs of the people living on the wing.

There was a system for evaluating the dependency levels of each resident.

Medication reviews were taking place.

Inspection Findings

C2 Is the service effective?

Our findings
Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence. The service does not require any improvements in this area.

This service was found to be effective.

Pre-admission assessments were completed in detail, with information then carried through into a combined care plan / risk assessment. Care plans identified people's level of independence.

Care records recorded people's involvement in decision-making, consent and mental capacity.

Information in the initial assessments and care plans in relation to mobility needs were clear. Equipment to aid mobility, such as walking aids had been provided to people.

Care plans and risk assessments were being regularly reviewed. They were also updated in between review dates. When falls had taken place, new risk factors had been clearly identified as well as what action had been taken.

Cognitive problems, dementia or a person's ability to manage their own safety were being considered. These factors were then carried forward into people's care plans / falls prevention plans.

There was evidence of timely involvement from and proactive referrals to other professionals and agencies.

The inspector was informed that staff knew people's needs well. A change in a person's circumstances were conveyed to staff via internal emails and on handover. In the event of a fall / near miss, accident forms were completed and also recorded on the home's computerised care record system.

Inspection Findings

C3 Is the service caring?

Our findings
Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. The service does not require any improvements in this area.

This service was found to be caring.

Silverdale provided a very welcoming and warm environment. Positive, respectful interactions between people and members of staff were observed. Staff were observed spending quality time with residents.

The manager knew the people in the home and their needs well.

Records evidenced that residents were fully involved / consulted following any fall with staff interventions discussed.

Inspection Findings

C4 Is the service responsive?

Our findings:
Responsive – this means we looked for evidence that the service met people's needs. The service does not require any improvements in this area.

This service was found to be responsive.

Initial assessments and care plans reflected what was important to people and how they were to be involved in their care.

The inspector was assured that the home was delivering care that was responsive to people's needs. Any fall triggered a review of need and interventions, such as 24hour observations, the person's GP notified and a urine dip test. Care records evidenced involvement from other professionals and agencies in response to a change of needs.

Assistive technology, such as room sensors/sensor mats, were being used to support better outcomes for people.

Inspection Findings

C5 Is the service well-led?

Our findings
Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture. The service does not require any improvements in this area.

This service was found to be well-led.

The manager and deputy manager were very welcoming and open to the unannounced inspection visit.

Information was disseminated to the staff team through team meetings, handovers and internal emails.

Care records evidenced that the home was seeking to continuously learn and improve following any fall, for example increasing / decreasing staff frequency of checking individual residents in their rooms.

Silverdale was proactive in submitting notifications in accordance to statutory requirements, therefore the inspector was aware of the number of falls within the home.

If areas of improvement have been identified the provider will be required to produce an action plan detailing how the areas of improvement will be rectified within the timescales identified. The R&I team will follow up and monitor any actions undertaken.