Unannounced Care Inspection Report
20 June 2017

The Martin Residential Trust

Type of Service: Nursing Home
Address: 48 Ballyclare Road, Glengormley, BT36 5HL
Tel No: 028 9034 2365
Inspector: Gerry Colgan

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care for up to 19 persons.

3.0 Service details

Organisation/Registered Provider: The Martin Residential Trust **Responsible Individual(s):** Mr James Smiley Martin Lisa McFarland	**Registered Manager:** Mrs Penny McCanny
Person in charge at the time of inspection: Mrs Penny McCanny	**Date manager registered:** 1 April 2005
Categories of care: Nursing Home (NH) LD – Learning disability. LD(E) – Learning disability – over 65 years.	**Number of registered places:** 19

4.0 Inspection summary

An unannounced inspection took place on 20 June 2017 from 08:20 to 15:00.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes 2015.

The inspection assessed progress with any areas for improvement identified during the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management, the home's environment, record keeping, audits and reviews, communication between residents, staff and other key stakeholders. There were also examples of good practice found in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients, good governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships. There were no areas identified for improvement during this inspection.

Patients spoken with said they were very well cared for at the Martin Residential Trust. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Penny McCanny registered manager and Lisa McFarland director, as part of the inspection process and can be found in the main body of the report.

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

4.2 Action/enforcement taken following the most recent inspection dated 14 February 2017

The most recent inspection of the home was an unannounced finance inspection undertaken on 14 February 2017. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report

During the inspection the inspector met with 17 patients, 11 staff, and one relative. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives and eight for patients were left for distribution.

The following records were examined during the inspection:

- duty rotas for all staff from 11 June 2017 to 1 July 2017
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- three staff recruitment and induction files
- three patient care records
- three patient care charts including food and fluid intake charts and repositioning charts
- staff supervision and appraisal planners
- a selection of governance audits

- patient register
- complaints record
- compliments received
- RQIA registration certificate
- certificate of public liability
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 14 February 2017.

The most recent inspection of the Martin Residential Trust was an unannounced finance inspection.

The completed QIP was returned and approved by the finance inspector.

6.2 Review of areas for improvement from the last care inspection dated 14 September 2016

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 38.3 **Stated:** First time	The registered provider should ensure that the following documents are maintained in respect of each member of staff: • two written references, linked to the requirements of the job, one of which is from the applicants present or most recent employer • relevant qualifications or accredited training • the job description/personnel specification • records of the interview process	**Met**

	Action taken as confirmed during the inspection: A review of three staff personnel files employed since the last care inspection all contained two written references one of which was obtained from the most recent employer, relevant qualifications, job descriptions and records of the interview process.	
Area for improvement 2 **Ref**: Standard 39.2 **Stated:** First time	The registered manager should sign off all completed induction records	**Met**
	Action taken as confirmed during the inspection: Three staff personnel files for recently employed staff all contained completed induction records signed by the registered manager. ..	
Area for improvement 3 **Ref**: Standard 18 **Stated:** First time	The registered manager should ensure that where recliner seating has been used, appropriate risk assessments have been completed and care plans developed and reviewed using a multidisciplinary approach and including relatives where appropriate.	**Met**
	Action taken as confirmed during the inspection: Records for two residents who use recliner seating were reviewed and contained a seating risk assessment. Care plans were developed using a multidisciplinary approach.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met.

A review of the staffing rota for weeks commencing 11, 18 and 25 of June 2017 evidenced that the planned staffing levels were adhered to. Staff consulted confirmed that staffing levels were good and met the assessed needs of the patients. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Staff recruitment information was available for inspection and records were maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work and records were maintained.

Discussion with staff and review of three personnel records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

Discussion with the registered manager and review of training records evidenced that they had a robust system in place to ensure staff attended mandatory training. Review of the training matrix for 2016/17 indicated that mandatory training requirements were being met. Observation of the delivery of care evidenced that training had been embedded into practice.

Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility. Staff appraisals are completed annually.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC).

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns.

Discussion with the registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified. A review of documentation confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately. Where any shortcomings were identified safeguards were put in place.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Action plans were in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous care inspection confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included observations of all bedrooms, bathrooms, lounges, dining room and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. A patient's relative and staff spoken with were complimentary in respect of the home's environment.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home's environment.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians.

Supplementary care charts such as daily activity records and food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislation.

Review of three patient care records evidenced that registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. Patients' records were maintained in accordance with Schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005.

There was evidence that the care planning process included input from patients and their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' condition.

Registered nurses were aware of the local arrangements and referral process to access other relevant professionals including General Practitioner's (GP), SALT, dietician, TVN. Discussion with staff and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

Discussion with the registered manager confirmed that senior staff meetings were held on a monthly basis and general staff meetings three monthly. Records were maintained.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the registered manager

All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Discussion with the registered manager and review of records evidenced that some patient relatives attend the board of Governors meetings. Minutes were available.

A patient representative spoken with expressed confidence in raising concerns with the home's staff and management. There was information available to staff, patients, representatives in relation to advocacy services.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping, audits and reviews, communication between residents, staff and other key stakeholders.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Many patients cannot communicate verbally. Staff interactions with all patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Discussion with the registered manager and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. There was evidence that suggestions for improvement had been considered and used to improve the quality of care delivered.

Consultation with two patients individually, confirmed that The Martin Residential Trust was a good place to live. One patient made the following comment.

"I love it here".

Four staff questionnaires were returned. All four staff were very satisfied that the care was safe, effective, compassionate and well led. No comments were received.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities.

A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with staff and a patient's relative evidenced that the registered manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed. Discussion with the registered manager and review of records and observation evidenced that the home was operating within its registered categories of care.

The registered manager confirmed that the policies and procedures for the home were systematically reviewed on a three yearly basis. Staff confirmed that they had access to the home's policies and procedures.

There were no complaints since the previous care inspection. Discussion with the registered manager confirmed that complaints would be managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

A copy of the complaints procedure was available in the home and staff were knowledgeable of the complaints process. Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvement had been embedded into practice.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner.

There were systems in place to ensure that risk assessments regarding the management of the environment were completed and kept under review.

Discussion with the registered manager and review of records evidenced that unannounced quality monitoring visits were completed on a monthly basis in accordance with the regulations. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, staff and trust representatives.

Discussions with staff and observations during the inspection confirmed that there were very good working relationships and that management were responsive to any suggestions or concerns raised.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

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