Unannounced Care Inspection Report
14 September 2016

The Martin Residential Trust

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

1.0 Summary

An unannounced inspection of The Martin Residential Trust took place on 14 September 2016 from 09.45 to 16.00 hours. On this occasion the inspector was accompanied by Kieran Murray, bank inspector.

The inspection sought to assess progress with issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

The environment of the home was warm, well decorated, fresh smelling and clean throughout. There was evidence of competent and safe delivery of care on the day of inspection. Staff were required to attend mandatory training and the observation of care delivery evidenced that knowledge and skills gained, through training, was embedded into practice. Staff also confirmed that there were good communication and support systems in the home, including; staff appraisal and staff supervision systems, staff meetings and staff were required to attend a 'handover meeting' when commencing duty. Some weaknesses were identified in respect of recruitment and induction records. Two recommendations have been made.

Is care effective?

There was evidence of positive outcomes for patients. All staff demonstrated a high level of commitment to ensuring patients received the right care at the right time. Each staff member understood 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 the patients, their representatives and other staff members.

One recommendation has been made in respect of the use of reclining chairs and the management of restrictive practices.

Is care compassionate?

Staff interactions with 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.

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.

Responses received from one patient, two patients' representatives and staff would indicate a high level of satisfaction with this service.

There were no requirements or recommendations made.

Is the service well led?

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.

Discussion with the registered manager and staff; and a review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided.

Complaints were managed in accordance with legislation. Notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

There were no requirements or recommendations made in the well led domain.

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 DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Penny McCanny, registered manager and Lisa McFarland, director, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 29 June 2016. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: The Martin Residential Trust/Reverend James Smiley Martin	**Registered manager:** Mrs Penny McCanny
Person in charge of the home at the time of inspection: Mrs Penny McCanny	**Date manager registered:** 01/04/2005
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 19

3.0 Methods/processes

Prior to inspection we analysed the following records:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit.

During the inspection we met with 15 patients, two relatives, two registered nurses, six care staff, one cook and one domestic staff.

Questionnaires for relatives (six) and staff (12) to complete and return were left for the registered manager to distribute. Two relatives and 12 staff completed and returned questionnaires within the required time frame.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- staff recruitment records
- staff training records
- staff induction records
- staff competency and capability assessments
- staff supervision and appraisal planner
- complaints and compliments records
- accident and incident records
- records of quality audits
- minutes of staff meetings
- monthly monitoring report
- annual quality report.
- three patient care records.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 04 November 2015

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

4.2 Review of requirements and recommendations from the last care inspection dated 04 November 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 19.6 **Stated:** First time	The registered manager should review the policy on communicating effectively to ensure it reflects the regional guidelines on breaking bad news	**Met**
	Action taken as confirmed during the inspection: A policy on communicating effectively was in place and reflected regional guidelines on breaking bad news.	
Recommendation 2 **Ref**: Standard 19 **Stated:** First time	The registered manager should provide training on communicating effectively/breaking bad news to nursing and care staff relevant to their roles and responsibilities	**Met**
	Action taken as confirmed during the inspection: This training was provided and attended by the majority of registered nurses and care staff in June 2016.	
Recommendation 3 **Ref**: Standard 19 **Stated:** First time	The registered manager should ensure that a palliative care link nurse has been identified for the home.	**Met**
	Action taken as confirmed during the inspection: The clinical lead nurse had been identified as the palliative care link nurse.	

Recommendation 4 **Ref**: Standard 20.1 **Stated:** First time	The registered manager should review the policies and procedures on the management of palliative and end of life care to ensure they reflect current best practice guidance such as the Gain Palliative Care Guidelines, November 2013.	**Met**
	Action taken as confirmed during the inspection: The policies and procedures on the management of palliative and end of life care had been reviewed on 04 January 2016 and reflected current best practice guidance.	
Recommendation 5 **Ref**: Standard 32 **Stated:** First time	The registered manager should provide training on palliative and end of life care for all staff relevant to their roles and responsibilities	**Partially Met**
	Action taken as confirmed during the inspection: We were informed that appropriate training was being sourced for the palliative care link nurse, while other staff had accessed on-line training in palliative care and communicating effectively.	

4.3 Is care safe?

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 rotas for the weeks commencing 28 August, 04 and 11 September 2016 evidenced that the planned staffing levels were adhered to.

Discussion with one patient, relatives and staff evidenced that there were no concerns regarding staffing levels.

The registered manager informed us that there were systems in place for the safe recruitment and selection of staff, and staff consulted confirmed that they had only commenced employment once all the relevant checks had been completed. Three personnel files were viewed and we identified a number of weaknesses in the documentation maintained. The following records were not available for inspection:

- a second reference for one member of staff
- relevant qualifications or accredited training for two members of staff
- the job description/personnel specification for two members of staff
- a record of interview for two members of staff.

This was discussed with the registered manager who agreed to follow up this issue. A recommendation has been made in this regard.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Staff were mentored by an experienced member of staff during their induction. Records for three staff members were reviewed and found to be well maintained. A recommendation has been made that the registered manager should sign off all completed induction records.

Review of the training matrix/schedule for 2016/17 indicated that training was planned to ensure that mandatory training requirements were met. Training records indicated that the majority of staff had completed mandatory training to date.

Staff clearly demonstrated the knowledge, skills and experience necessary to fulfil their role, function and responsibility.

A planner was in place to ensure all staff received supervision and appraisal and there was evidence that supervision and appraisal meetings had taken place with the majority of staff to date in 2016.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. A review of documentation confirmed that any potential safeguarding concerns were managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were also notified appropriately.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was sufficiently robust.

Review of 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.

Discussion with the registered manager confirmed that a range of audits was conducted on a regular basis (refer to section 4.6 for further detail). A sample of falls audits was reviewed and evidenced that the information had been 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 Home Regulations (Northern Ireland) 2005. Review of accidents/incidents records confirmed that notifications were forwarded to RQIA appropriately.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining room and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout.

Fire exits and corridors were observed to be clear of clutter and obstruction and equipment was appropriately stored.

Areas for improvement

Two recommendations have been made in respect of staff recruitment and induction records.

Number of requirements	0	**Number of recommendations**	2

4.4 Is care effective?

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 care had been assessed, planned, evaluated and reviewed in accordance with NMC guidelines. Risk assessments informed the care planning process.

Care records generally 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. We observed a number of patients seated in chairs which were reclined. This was discussed with the registered manager who confirmed that this measure was to ensure the safety of patients who were not independently mobile. It was agreed that risk assessments and care plans would be reviewed to reflect best practice guidelines in the management of this type of seating. Evidence should be available within care records to support the use of the reclining function, for example an occupational therapist report. A recommendation has been made accordingly.

Supplementary care charts such as repositioning and food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

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

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.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff also confirmed that regular staff meetings were held, that they could contribute to the agenda and the meeting and minutes were available. Staff confirmed they found the level of communication from the registered manager to be very good and clarified what was expected of them.

Patients' representatives expressed their confidence in raising concerns with the home's staff/management.

Areas for improvement

One recommendation has been made in respect of patients seating and the management of restrictive practices.

Number of requirements	0	**Number of recommendations**	1

4.5 Is care compassionate?

Staff interactions with 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.

We were informed that the majority of patients living in the home did not use speech to communicate and in these cases the views of patients were interpreted by staff following assessment of non-verbal communication. 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.

Observation of the lunch time meal confirmed that patients were given a choice in regards to, food and fluid choices and the level of help and support requested. Staff were observed to offer patients reassurance and assistance appropriately. The daily menu was displayed in the dining rooms and offered patients a choice of two meals for lunch and dinner. A choice was also available for those on therapeutic diets.

We spoke with one patient who was complimentary regarding the care they received and life in the home. The patient told us that everything was "very good" and they enjoyed their trip out in the minibus.

An individualised programme of activities was provided for all patients. We were informed that two or three patients go out on minibus trips each day to a restaurant or shopping. Other patients were engaged in arts and crafts or gardening in the enclosed garden attached to the day centre. Some patients enjoyed hand/feet massages, while other relaxed in the multisensory room.

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. Views and comments recorded were analysed and an action plan was developed and shared with staff, patients and representatives.

As part of the inspection process, we issued questionnaires to staff and patients' representatives. Two relatives and 12 staff completed questionnaires. Some comments are detailed below.

Staff

- "We all work well as a team."
- "I'm content here, I love my job."
- "I have been working her for a long time and enjoy my work."
- "We have regular staff meetings and training."

Patients' representatives

- "I'm very pleased with the care provided."
- "The staff are all very good. I have no complaints."

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were knowledgeable in regards to their roles and responsibilities. Staff also confirmed that there were good working relationships and stated that management were responsive to any concerns raised.

The certificate of registration issued by RQIA was displayed in the home.

A certificate of public liability insurance was current and displayed.

Discussion with the registered manager, a review of care records and observations confirmed that the home was operating within its registered categories of care.

Review of the home's complaints record and discussion with the registered manager evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Patients' representatives confirmed that they were aware of the home's complaints procedure.

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 staff, 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, care records, infection prevention and control, environment, complaints and 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 improvements had been embedded into practice.

Review of records for June, July and August 2016 evidenced that Regulation 29 monthly quality monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement. 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.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Penny Mc Canny, registered manager and Lisa McFarland, director, as part of the inspection process. The timescales commence from the date of inspection.

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

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

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements – None

Recommendations

Recommendation 1 **Ref**: Standard 38.3 **Stated:** First time **To be completed by:** 30 September 2016	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. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: All files now include 2 written references. Files of new employees now contain; copies of qualifications and accredited training, interview records, job description and specifications. Records of training and qualifications to be included in the personnel files of all staff including those already in employment.
Recommendation 2 **Ref**: Standard 39.2 **Stated:** First time **To be completed by:** 30 September 2016	The registered manager should sign off all completed induction records **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Induction records now countersigned by the registered manager.
Recommendation 3 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 31 October 2016	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. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: A risk assessment has been drawn up and is in place in all care plans. Further discussion with multidisciplinary team will be undertaken during reviews.

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

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