Announced Primary Inspection

Name of Establishment:	**The Martin Residential Trust**
Establishment ID No:	**1380**
Date of Inspection:	**22 September 2014**
Inspector's Name:	**Bridget Dougan**
Inspection No:	**IN017126**

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 8225 2544

1.0 General Information

Name of Home:	The Martin Residential Trust
Address:	48 Ballyclare Road Glengormley BT36 5HL
Telephone Number:	028 9034 2365
E mail Address:	nigel@mrtrust.org.uk
Registered Organisation/ Registered Provider:	The Martin Residential Trust The Reverent James Martin
Registered Manager:	Mrs Penny McCanny
Person in Charge of the Home at the time of Inspection:	Mrs Penny McCanny
Registered Categories of Care and number of places:	Nursing - LD, LD (E)
Number of Registered Places:	19
Number of Patients/Residents Accommodated on Day of Inspection:	18
Date and time of this inspection:	22 September 2014: 11.45 – 15.45 hours
Date and type of previous inspection:	04 February 2014 Primary Announced Inspection

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 Mrs Penny McCanny, registered manager
- discussion with Mrs Lisa McFarland, Director

- 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	**16**
Staff	**8**
Relatives	**5**
Visiting Professionals	**0**

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	**0**	**0**
Relatives / Representatives	**3**	**3**
Staff	**4**	**2**

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

The Martin Residential Trust is situated on the outskirts of the village of Glengormley, convenient to public and local amenities.

It is a two storey purpose built nursing home providing all the patient accommodation on the ground floor. Bedroom accommodation is provided in one double and 17 single rooms. Overhead moving and handling equipment has been installed in many of the patients' bedrooms, as assessed appropriate. There are two communal lounges, a dining room, bath/shower/toilet facilities, a Jacuzzi and a multi-sensory room. Offices and stores are located on the first floor.

A purpose built day centre has recently been added to the home. This area includes a multisensory room, kitchen, day area, activity room and toilets. An enclosed courtyard with raised beds is to the rear of the day centre.

Access to the Nursing Home is at ground level via the car park. Entrance to the grounds of the home is shared by Fold accommodation and a Church.

The home is registered to provide accommodation for 19 persons over and under the age of 65 with learning disabilities.

8.0 Summary of Inspection

This summary provides an overview of the services examined during an announced primary care inspection to Martin Residential Trust. The inspection was undertaken by Bridget Dougan on 22 September 2014 from 11.45 – 15.45 hours.

The inspector was welcomed into the home by Mrs Lisa McFarland, Director and Mrs Penny McCanny, Registered Manager. Feedback was provided at the conclusion of the inspection to Mrs McCanny and Mrs McFarland.

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

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. This self-assessment was received by RQIA in a timely manner and the inspector has been able to evidence that the level of compliance achieved with the standards inspected was higher than that recorded in the self-assessment. 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, their representatives and staff to seek their opinions of the quality of care and service delivered. The inspector also examined the returned questionnaires from patients', representatives, staff, 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.

The inspector also spent two 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 was designed to help evaluate the type and quality of communication which takes place in the nursing home.

As a result of the previous inspection conducted on 04 February 2014 three recommendations were issued. These were reviewed during this inspection and the inspector evidenced that all recommendations have 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)

8.1 Inspection findings

8.1.1 Management of nursing care – Standard 5

The inspector can confirm that at the time of the inspection there was evidence to validate that patients received safe and effective care in The Martin Residential Trust.

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 need 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 health and social care trust (HSCT) maintained appropriate reviews of the patient's satisfaction with the placement in the home, the quality of care delivered and the services provided.

COMPLIANCE LEVEL: Compliant

8.1.2 Management of wounds and pressure ulcers – Standard 11 (selected criteria)

The inspector was informed by the registered manager that none of the patients currently accommodated had wounds/pressure ulcers.

There was evidence of appropriate assessment of the risk of development of pressure ulcers which demonstrated timely referral to tissue viability specialist nurses (TVN) for guidance and referral to the HSCT regarding the supply of pressure relieving equipment if appropriate.

Care plans for the management of risks of developing pressure ulcers were maintained appropriately.

COMPLIANCE LEVEL: Compliant

8.1.3 Management of nutritional needs and weight loss – Standard 8 and 12 (selected criteria)

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

Robust systems were evidenced with risk assessments and appropriate referrals to General Practitioners (GP's), speech and language therapists (SALT) and or dieticians being made as required.

The inspector also observed the serving of the lunch time meal and can confirm that patients were offered a choice of meal and that the meal service was well managed and supervised by registered nurses.

Patients were observed to be assisted with dignity and respect throughout the meal.

A recommendation has been made for catering staff to receive update training in nutrition.

COMPLIANCE LEVEL: Compliant

8.1.4 Management of dehydration – Standard 12 (selected criteria)

The inspector examined the management of dehydration during the inspection which evidenced that fluid requirements and intake details for patients were recorded and maintained for those patients assessed at risk of dehydration.

Patients were observed to be able to access fluids with ease throughout the inspection. Staff were observed offering patients additional fluids throughout the inspection. Fresh drinking water/various cordials were available to patients in lounges, dining rooms and bedrooms.

COMPLIANCE LEVEL: Compliant

8.3 Patient, representatives and staff questionnaires

The inspector was informed that most of the patients living in the home do not use speech to communicate and in these cases the views of the person are interpreted following assessment of non-verbal communication. The inspector observed that patients appeared relaxed and content in their environment. Some comments received from those patients who were able to verbalise their views and from their representatives:

- “This is a great home.”
- “I am very happy here.”
- “The Martin Residential Trust is an excellent home. The staff very friendly and helpful and can’t do enough for you.”
- “Staff are great with the residents.”
- “The home is a happy and welcoming place.”

Some comments received from staff:

- “I am very happy here. There is good management and team work. It is a very pleasant place to work.”
- “I have had a good induction experience and felt well prepared for my role.”
- “The patients in the Martin Residential Trust are very well cared for.”
- “I would be very happy to recommend the Martin Residential Trust to anyone seeking a place for a friend or family member. The needs of the residents are always put first.”

8.4 A number of additional areas were also examined.

- Records required to be held in the nursing home
- Human Rights Act 1998 and European Convention on Human Rights (ECHR)
- Patient and staff quality of interactions (QUIS)
- Complaints
- patient finance pre-inspection questionnaire
- NMC declaration
- Staffing/staff comments
- Environment.

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

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

The home’s general environment was well maintained and patients were observed to be treated with dignity and respect. However one area for improvement was identified in relation to update training in nutrition for catering staff.

Therefore, one recommendation is raised as a consequence of this inspection and is detailed in the quality improvement plan (QIP).

The inspector would like to thank the patients and their representatives, the home management, registered nurses and staff for their assistance and co-operation throughout the inspection process.

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

9.0 Follow-up on the recommendations issued as a result of the previous inspection

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	25.2	It is recommended that the results of the quality assurance questionnaires/annual quality review report should be prominently displayed in the home and made available to patients/relatives.	The inspector reviewed the annual quality review report and can confirm that this recommendation has been met.	**Compliant**
2	16.3	It is recommended that the nurse in charge competency assessments include staff awareness of their role in dealing with, and responding to, allegations of suspected abuse.	Review of a sample of nurse in charge competency assessments evidenced that this recommendation has been met.	**Compliant**
3	10.7	It is recommended that a record is maintained of the times of release of the lap straps.	The inspector observed the record of the times of release of the lap straps and can confirm that this recommendation has been met.	**Compliant**

9.1 Follow- up on any issues /concerns raised with RQIA since the previous inspection such as complaints or safeguarding investigations.

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if there is considered to be a breach of regulation as stated in the Nursing Homes Regulations (Northern Ireland) 2005, RQIA has a responsibility to review the issues through inspection.

Since the previous care inspection on 04 February 2014, RQIA have received no notifications of safeguarding of vulnerable adult (SOVA) incidents in respect of The Martin Residential Trust.

10.0 Additional Areas Examined

10.1 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.

10.2 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.

10.3 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 either available in the home or sourced at the time of the inspection.

10.4 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 interactions between patient and staff during the serving of lunch in the dining room. The inspector also observed care practices in the main sitting rooms following the lunch meal.

The observation tool used to record this observation uses a simple coding system to record interactions between staff, patients and visitors to the area being observed.

Positive interactions	All positive
Basic care interactions	
Neutral interactions	
Negative interactions	

The inspector evidenced that the quality of interactions between staff and patients was positive.

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

10.5 Complaints

Prior to the inspection a complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. No complaints were recorded since the previous inspection.

10.6 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.

10.7 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.

10.8 Questionnaire findings

10.8.1 Staffing/staff comments

On the day of inspection the inspector examined staff duty rosters for three 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 with eight staff members during the inspection process.

Examples of staff comments were as follows:

- "I am very happy here. There is good management and team work. It is a very pleasant place to work."
- "I have had a good induction experience and felt well prepared for my role."

10.8.2 Patients' comments

The inspector was informed that most of the patients living in the home do not use speech to communicate and in these cases the views of the person are interpreted following assessment of non-verbal communication. The inspector observed that patients appeared relaxed and content in their environment. Some comments received from those patients who were able to verbalise their views:

- "I am very happy with the care provided in this home. When I am not here to get information, it is related to other members of my family."

10.8.3 Patient representative/relatives' comments

During the inspection the inspector spoke with five representatives/relatives. In addition, three representatives/relatives competed and returned questionnaires.

The following are examples of relatives' comments during inspection and in questionnaires;

- "This is a great home."
- "I am very happy here."
- "The Martin Residential Trust is an excellent home. The staff very friendly and helpful and can't do enough for you."
- "Staff are great with the residents."
- "The home is a happy and welcoming place."

10.9 Environment

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

The home was clean, warm and comfortable. The ambience in the home was relaxed and friendly.

11.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Penny McCanny, Registered Manager 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:

Bridget Dougan
The Regulation and Quality Improvement Authority
Hilltop
Tyrone & Fermanagh Hospital
Omagh
BT79 0NS

Appendix 1

<table>
<tr><th colspan="2">Section A</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>There is no single validated risk assessment tool available to meet this criterion, however the DHSSPSNI 'Nursing Needs Assessment Tool' is used prior to admission to identify needs and risks and this is used in conjuction with multidisciplinary risk assessments to support the completion of the care plan. Prior to admission all required individual risk assessments for example; Braden, Community Nutritional Risk Scoring Tool, Use of bed rails, falls risk assessment are completed and are reviewed again on admission. A nursing care plan is in place prior to the day of admission.</td><td>Compliant</td></tr>
</table>

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**
Each resident has a named nurse who is responsible for assessing, planning, implementing and evaluating their nursing needs and care. The nurse works within a multidisciplinary team in order to ensure all needs are met. In relation to nutrition, referrals are made to the dietitian according to the protocols provided by the dietetic service. Where it is thought that the resident has difficulties in swallowing an additional referral is made to the speech and	Substantially compliant

language therapist requesting assessment and advice. With regard to issues relating to tissue viability, referrals are made through the resident's GP service.	
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**
The Roper, Logan and Tierney model of care is used within the home to provide a structure for our assessment of need. Prior to admission, thorough assessments are carried out by the Martin Residential Trust nursing team and by the multidisciplinary professionals who work with the person who is seeking admission. Families and advocates are involved in this process and the Martin Residential Trust care plan is informed by those assessments as well as by the views and choices of the person seeking admission. It is our policy to review the whole nursing care package at least once every 3 months but specific needs may be reviewed more frequently. All reviews are recorded in the care plan.	Substantially 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**
Practice is underpinned by solid and research based theory. In relation to skin care and prevention of pressure ulcers the following resources are used to inform policy and practice: NICE guidelines 2014 and the European Pressure Ulcer Advisory Panel website. In addition we access up to date information on sites such as Healthcare Improvement Scotland and NICE Health and Social Care Evidence Search. The Braden risk scoring tool is used to assess risk of pressure ulcer. Nursing interventions are carried according to the assessed score and recommended implementations. Nutritional guidelines from the Public Health Agency, the dietetic department of the Northern Health and Social Care Trust and individual dietetic care plans are available for use by all staff.	Substantially compliant

<table>
<tr><th colspan="2">Section E</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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</td><td></td></tr>
<tr><td>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>Each resident has a nursing care plan. Included in the care plan are nursing interventions, an activity schedule and a record of any nursing or therapeutic procedures carried out. Outcomes are recorded in the care plan both in the daily statement and under the specific identified need.
There is a record kept of all meals provided as well as the specific food and drink consumed by every resident. Difficulties experienced by a resident are highlighted in the report and the care plan and additional measures identified to support the resident are agreed. Ongoing issues are discussed with the resident and their relative. Most of the people living in the home do not use speech to communicate and in these cases the views of the person are interpreted following assessment of non-verbal communication. Where appropriate, and according to the protocol identified in the Trust dietetic guidelines, a referral is made to the dietitian or another member of the multidisciplinary team for assessment and advice.</td><td>Substantially compliant</td></tr>
</table>

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**
A daily statement is recorded of the resident's health and well being. In addition a review of nursing interventions is carried out at least once every 3 months or as stipulated by the person prescribing care or according to the needs or wishes of the resident or their relative. Most of the residents living in the Martin Residential Trust do not use speech to communicate, as a result their views are based on an interpretation of non-veral communication including, facial expressions, mood and body language. Relatives are invited to annual reviews and we encourage relatives to discuss their concerns and opinions with us not only at this meeting but at any time throughout the year. Relatives are also provided with a confidential, and if they wish an anonymous, questionnaire asking for their opinions about the services that we provide.	Substantially compliant

<table>
<tr><th colspan="2">Section G</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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)</td><td></td></tr>
<tr><td>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>Relatives are invited to attend multidisciplinary reviews with the HSC Trust. If able to do so, residents also attend reviews. A record of all meetings is recorded in the care plan and minutes are provided by the the HSC Trust representative. Following the review the care plan is updated and a plan agreed that will assist the resident to meet goals.</td><td>Substantially compliant</td></tr>
</table>

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**
The people living in the home are provided with a diet that meets all of the standards required by dietetic services, the commissioning trust and as outlined in the document 'Nutritional guidelines and menu checklist for residential and nursing homes 2014'. Individual needs and preferences are addressed when creating the menu. Where a resident, including those on specific diets, does not want a meal, an alternative is always provided. The menu is audited every 3 months to ensure that it continues to meet these standards as well as the needs of residents. Changes to the menu are made regularly with substantial changes made at least twice per year.	Substantially compliant

<table>
<tr><th colspan="2">Section I</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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</td><td></td></tr>
<tr><td>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>In the last year all staff have received training in nutrition and dysphagia. This training is provided in-house on an annual basis and has been augmented this year by training from the speech and language therapist.
Breakfast is normally provided between 07:30 and 09:30, lunch between 12:30 and 14:00 and dinner between 17:15 and 18:00. Supper is offered after 20:30 and drinks are offered at intervals throughout the day. However, residents who wish to eat outside of these times are supported to do so. Adapted utensils are available to assist individuals to</td><td>Substantially compliant</td></tr>
</table>

eat and drink safely as well as to facilitate independence. Staff are trained in offering safe and appropriate assistance at meals. Full records are maintained of all food and fluids taken and, where issues arise or risks identified, staff are informed via the report, the care plan and at daily information updates. A number of nursing staff have attended tissue viability training. Wound management plans are drawn up by nurses who are competent to do so. The level of nursing expertise required to assess the wound and prescribe care will depend on the specific wound type and severity. In the event that a wound management plan has been put in place advice and training will be provided by competent nursing staff either in the home or from those working in external nursing teams.	

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	COMPLIANCE LEVEL
	Substantially compliant

Appendix 2

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

<table>
<tr><td>Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.</td><td>Negative (NS) – communication which is disregarding of the residents’ dignity and respect.</td></tr>
<tr><td>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</td><td>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</td></tr>
</table>

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

The Martin Residential Trust

22 September 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 Penny McCanny, Registered Manager 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	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
		No Requirements were made as a result of this inspection.			

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	Recommendation	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	12.1	The registered manager should ensure that all catering staff receive update training in nutrition **Reference: Section 8.1**	One	Training arranged for all catering staff and will be completed by the 26th November 2014	Within one month from receipt of this QIP

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	Penny McCanny
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	James Martin

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Bridget Dougan	10 November 2014
Further information requested from provider			