The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: The Martin Residential Trust

Provider: The Martin Residential Trust

Date of Inspection: 6 March 2025

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider:	The Martin Residential Trust
Responsible Individual:	Mrs Lisa McFarland
Registered Manager:	Mr Martin Kelly
Service Profile – This is a registered nursing home which provides nursing care for up to 19 persons with a learning disability. Patient bedrooms are located over one floor. Patients have access to communal lounges, a dining room and a patio garden area at the rear of the home.	

2.0 Inspection summary

An unannounced inspection took place on 6 March 2025 from 9:40 am to 3:40 pm by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that safe, effective and compassionate care was delivered to patients and that the home was well led. Details and examples of the inspection findings can be found in the main body of the report.

It was evident that staff promoted the dignity and well-being of patients and that staff were knowledgeable and well trained to deliver safe and effective care.

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patients, relatives, staff or the commissioning trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Patients told us they were happy with the care and services provided. Comments made included "staff treat me very well" and "I love it here; I enjoy the company".

Discussion with patients confirmed that they were able to choose how they spent their day. For example, patients could have a lie in or stay up late to watch TV.

Patients told us that staff offered choices to patients throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options, and where and how they wished to spend their time.

Staff spoke in positive terms about the provision of care, their roles and duties, training and managerial support.

Compliments received about the home were kept and shared with the staff team with comments such as "It is very much like a family home for these patients" by a student nurse whilst on placement in the home.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of patients. Review of newly appointed staff recruitment records evidenced that reasons for gaps in employment were not always explored. An area for improvement was identified.

Patients said that there was enough staff on duty to help them. Staff said there was good team work and that they felt well supported in their role and that they were very satisfied with the staffing levels. Staff were seen to respond to requests for assistance in a timely manner and were courteous towards each other and any visitors to the home.

3.3.2 Quality of Life and Care Delivery

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner. Interactions between staff and patients were seen to be warm and engaging.

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable of individual patients' needs, their daily routine wishes and preferences. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs.

Staff were observed to be prompt in recognising patients' needs and any early signs of distress or illness, including those patients who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner, and by offering personal care to patients discreetly. Staff were also observed offering patient choice in how and where they spent their day or how they wanted to engage socially with others.

At times some patients may require the use of equipment that could be considered restrictive or they may live in a unit that is secure to keep them safe. It was established that safe systems were in place to safeguard patients and to manage this aspect of care.

Patients who were less able to mobilise were assisted by staff to change their position. Records evidenced that the patients were repositioned however, the frequency of repositioning carried out was not consistent with the recommended regime recorded in the patient records and some of the records reviewed did not evidence that skin checks were being carried out. An area for improvement was identified.

Where a patient was at risk of falling, measures to reduce this risk were put in place.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this may include simple encouragement through to full assistance from staff and their diet modified.

Observation of the lunch time meal, review of records and discussion with patients, staff and the manager confirmed that there were robust systems in place to manage patients' nutrition and mealtime experience. An effective system was in place to identify which meal was for each individual patient, to ensure patients were served the right consistency of food and their preferred menu choice. Patients were able to avail of the dining room or other communal areas as preferred for the serving of their meals and adequate numbers of staff were observed assisting patients with their meal appropriately, in an unhurried manner and a registered nurse was overseeing the mealtime. Patients told us that they enjoyed their meal.

Discussions with staff evidenced that patients were not routinely offered a choice of meal at the evening time meal. There was no listed second option on the menu displayed. This was identified as an area for improvement.

Discussion with staff confirmed that the planned menu was not always adhered to due to a number of external factors. Assurances were given that a menu variation record would be put in place. This will be reviewed at the next inspection.

The importance of engaging with patients was well understood by the manager and staff. Life story work with patients and their families helped to increase staff knowledge of their patients' interests and enabled staff to engage in a more meaningful way with their patients throughout the day.

Staff understood that meaningful activity was not isolated to the planned social events or games. Patients' needs were met through a range of individual and group activities. Birthdays and annual holidays were celebrated.

Activity records were maintained which included the patient engagement with the activity sessions. Patients also have access to a sensory room.

Staff were observed sitting with residents and engaging in discussion. Residents who preferred to remain private were supported to do so and had opportunities to listen to music or watch television or engage in their own preferred activities.

Arrangements were in place to meet patients' social, religious and spiritual needs within the home.

3.3.3 Management of Care Records

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment, care plans and risk assessments should be developed in a timely manner to direct staff on how to meet the patients' needs. However, in one patient's care record, care plans had not been developed in a timely manner; this was identified as an area for improvement.

Patients care records were held confidentially.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Nursing staff recorded regular evaluations about the delivery of care. Patients, where possible, were involved in planning their own care and the details of care plans were shared with patients' relatives, if this was appropriate.

3.3.4 Quality and Management of Patients' Environment

The home was clean, tidy and well maintained. For example, patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable.

Observation of the environment identified concerns that had the potential to impact on patient safety; there was access to toiletries in a communal bathroom and an air freshener in the sensory room. This was identified as an area for improvement.

Review of records and observations confirmed that systems and processes were in place to manage infection prevention and control which included policies and procedures and regular monitoring of the environment and staff practice to ensure compliance.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mr Martin Kelly has been the manager in this home since December 2021.

Patients and staff commented positively about the management team and described them as supportive, approachable and able to provide guidance.

Review of a sample of records evidenced that a robust system for reviewing the quality of care, other services and staff practices was in place. There was evidence that the manager responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and/or the quality of services provided by the home.

Patients said that they knew who to approach if they had a complaint and had confidence that any complaint would be managed well.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with regulations and standards.

	Regulations	Standards
Total number of Areas for Improvement	1	4

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Martin Kelly, manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 14 (2) (a) **Stated:** First time **To be completed by:** 6 March 2025	The registered person shall ensure as far as reasonably practical that all parts of the home to which patients have access are free from hazards to their safety. Ref: 3.3.4 **Response by registered person detailing the actions taken:** All storage cupboards in communal bathrooms with child locks are closed daily when not in use, This is checked daily by nurse in charge and by the manager.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 38 **Stated:** First time **To be completed by:** 6 March 2025	The registered person shall ensure that gaps in employment are explored in full before staff commence working in the home. Ref: 3.3.1 **Response by registered person detailing the actions taken:** All gaps in employment history are discussed and documented at interview level.
Area for improvement 2 **Ref:** Standard 23 **Stated:** First time **To be completed by:** 30 April 2025	The registered person shall ensure that patients are repositioned in keeping with their prescribed care and the condition of the patients' skin is recorded. Ref: 3.3.2 **Response by registered person detailing the actions taken:** All residents prescribed care regarding repositioning has been reviewed and their repositioning charts reflect their precribed care, this is reviewed by Primary nurse and audited by the manager

Area for improvement 3 **Ref:** Standard 12.13 **Stated:** First time **To be completed by:** 6 March 2025	The registered person shall ensure that the menu offers patients a choice of meal at each mealtime. Ref: 3.3.2
	Response by registered person detailing the actions taken: There are now two choices of meals Displayed in the dining room and on offer at meal times
Area for improvement 4 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 6 March 2025	The registered person shall ensure that a system is in place to monitor the timely completion of care records following a patient's admission to the home. Ref: 3.3.3
	Response by registered person detailing the actions taken: All new admissions are allocated a Primary Nurse and all care records are audited and reviewed within 48 hrs of admission.

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