Martha Trust

# Martha House

## Inspection report

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## Ratings

| Overall rating for this service | Requires improvement |
|---|---|
| Is the service safe? | Requires improvement |
| Is the service effective? | Requires improvement |
| Is the service caring? | Good |
| Is the service responsive? | Requires improvement |
| Is the service well-led? | Requires improvement |

## Overall summary

This inspection took place on 6 and 7 Mary 2015, was unannounced. The previous inspection on 20 September 2013 found there were no breaches in the legal requirements.

Martha House provides nursing and personal care and accommodation for up to 13 young adults with profound and multiple learning and physical disabilities. There were 12 people living at the service and one person on respite care during the inspection. People were unable to communicate verbally and used body language, facial expressions and some vocal sounds to make their needs known. There are two buildings in the service, Martha House and Frances House. Both premises are arranged over one floor, containing bedrooms, communal lounges and dining areas. All of the bedrooms are spacious, with hoist systems in place. The shared toilets and bathrooms also have hoist systems in place. There is parking available on site, and there are other facilities in the complex, including hydrotherapy.

A registered manager was in post; however they were not available at the time of the inspection due to annual leave. A registered manager is a person who has

# Summary of findings

registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The deputy manager, together with senior staff, assisted with the inspection process.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The registered manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). One application had been made to the DoLS department to depriving the person of their liberty for their own safety.

Risks to people were identified but full guidance on how to safely manage the risks was not always available. This left people at risk of not receiving the support they needed to keep them as safe as possible. Accidents and incidents were recorded but had not been summarised to identify if there were any patterns or if lessons could be learned to support people more effectively to ensure their safety.

People received their medicine on time however it was not always managed as safely as possible.

Staff told us about the training they had received and there was an on-going training programme in place. Further specialist training was needed to make sure staff had the skills and understanding of people's individual needs. The service had recognised that the induction training for new staff needed to be improved. Staff were not receiving regular supervisions, including clinical supervision for the nursing staff. Staff appraisals were not up to date to give staff the opportunity to discuss their training and development needs.

People's needs had been assessed to identify the care they needed, however care plans varied in detail to ensure personalised care was being provided. Some care plans lacked clear detail to show how people were receiving the care they needed. Family members supported their relatives and were involved in their care planning.

Some relatives and staff did not think the registered manager was visible within the service and was not monitoring the quality of service effectively. Actions from the care plan audit had not been implemented within the timeframe agreed to improve the standard of personalised care planning.

Relatives were asked for their feedback about the service, but the views from staff and health care professionals had not been sought to continuously improve the service. Records were not always accurate or completed properly.

Relatives told us that they had confidence that their relatives were safe living at the service. They were also confident to raise any concerns or issues with the registered manager and staff.

Relatives and staff told us that at times there was not enough staff to make sure people received the one to one time they required. The deputy manager told us that new staff had been recruited and this should not happen in the future. At the time of the inspection there was sufficient staff on duty and one to one hours had been allocated to individual staff. Recruitment procedures ensured new members of staff received appropriate checks before they started work. All staff had been trained in safeguarding adults, and discussions with them confirmed that they knew the action to take in the event of any suspicion of abuse. Staff were aware of the whistle blowing policy and were confident they could raise any concerns with the registered manager or outside agencies if necessary.

Checks were done to ensure the premises were safe, such as fire safety checks. Equipment to support people with their mobility, such as the ceiling hoists had been serviced to ensure that it was safe to use.

People were supported to have a varied and balanced diet. Staff understood people's complex dietary needs and promoted people to eat as independently as possible. Staff were attentive; they treated people with kindness, encouraged their independence and responded to their needs.

People had the opportunity to participate in a varied activity programme. A system to receive, record, investigate complaints was in place so it was easy to track complaints and resolutions.

There was a mission statement on display in the service, which outlined the visions and values of the service, such as treating everyone with dignity and respect, supporting

# Summary of findings

and encouraging, and treating people with compassion. Staff were aware of these values and demonstrated their understanding of how to achieve this by offering people choice, treating them with dignity and responding to their needs.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions we have asked the provider to take at the end of this report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Requires improvement 

The service was not always safe.

Risks to people were assessed however guidance was not always available to make sure all staff knew what action to take to keep people as safe as possible.

Accidents and incidents were recorded and action taken, but these were not summarised to look for patterns or trends to reduce the risk of re –occurrence.

People's medicines were not always managed safely.

Sufficient staff were on duty and new staff had been recruited to make sure people received their one to one allocation of staff.

Recruitment procedures ensured new members of staff received appropriate checks before they started work.

**Is the service effective?**

Requires improvement 

The service was not always effective.

Staff induction and specialist training, together with supervision and appraisals were not up to date to ensure that staff were supported to fulfil their role.

Although best interest meetings had been held and deprivation of liberty authorisation applied for there were other restrictions of people's liberty, which had not been actioned in line with the Mental Capacity Act and DoLs safeguards.

Staff were knowledgeable about people's health needs, however care plans did not always reflect the care being provided to confirm they had received the care they needed.

The service provided a variety of food and drinks s that people received a nutritious diet.

**Is the service caring?**

Good 

The service was caring.

Staff communicated with people in a caring and compassionate way. If people were unable to communicate using speech staff made gestures and signs that they could understand.

People and their relatives were able to discuss any concerns regarding their care and support. People's privacy and dignity was respected.

People were supported by their family to be involved in their care and if required advocacy services were available.

# Summary of findings

**Is the service responsive?**

Requires improvement

The service was not always responsive

Families supported their relatives to be involved in their care planning. However care plans were not easy to follow and did not give staff clear guideline to ensure person centred care was being delivered.

Although there was verbal handovers at each shift, to keep staff up to date with people's changing needs, this information was not always reflected in the care plans.

People were supported in carrying out their preferred lifestyles and in taking part in activities of their choice.

People and their relatives said they would be able to raise any concerns or

complaints with the staff and registered manager, and their complaints would be responded to.

**Is the service well-led?**

Requires improvement

The service was not always well led.

Staff and relatives felt that the registered manager was not monitoring the service effectively.

Relatives and staff were asked for their views about the service through meetings and annual surveys. However, health care professionals and other stakeholders, such as professional bodies had not been included in the survey to give them the opportunity to voice their opinions of the quality of the service.

The audits in place to monitor the quality of the service were not effective as

Identified shortfalls in the care plans had not been actioned to improve the service. Records were not always accurate or completed properly.

The staff understood the vision and values of the service by treating people with dignity, respect and compassion.

# Martha House

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 and 7 May 2015 and was unannounced. The inspection was carried out by two inspectors, a specialist adviser, and an expert by experience. Another expert by experience made telephone calls to people's relatives. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection we spoke with 12 people's relatives, five nursing staff and ten care staff, the chef, the deputy manager, human resources staff and the chief executive of the Martha Trust. We observed staff carrying out their duties, communicating and interacting with people. We reviewed documents; we looked at eight care plans, medication records, five staff files, training information and some policies and procedures in relation to the running of the home. We also spoke with three health and social care professionals and the local authority learning disability team.

A Provider Information Return (PIR) was submitted by the service prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Requires improvement

# Is the service safe?

## Our findings

People indicated that they felt safe at the service. We observed they were relaxed in the presence of staff. Staff were very aware of what made people anxious or what signs to look for if they were unhappy. Relatives said they felt the service was safe. They said: "The staff are like family, they care". "Exceptional". "I would not leave my relative there if I didn't think it was safe".

All of the people living at the service needed support with their mobility. Risk assessments were in place but these did not all give staff clear guidance on how to reduce risks and move people safely. Assessments identified how many staff were needed to support a person and any specialist equipment that was needed, such as, slide sheet or hoist. However the detail in the assessments varied to show how people were being moved consistently and safely. One plan recorded that a person required the use of a hoist to move them when needed, it stated 'support of two staff' but there was no explanation of how this support should be given to ensure the person was moved safely. Another plan stated what colour hoist sling to use but there were no other details to guide staff how to support and manage the associated risks when moving this person. Other risk assessments showed how to move a person in and out of bed, and had clear details of how to do this safely, including what sling to use, where to place the sling, how to secure the straps and how high to raise the person. The service had recently recruited new staff and also used agency staff. The lack of detailed guidance therefore poses a risk to people being moved consistently and safely.

Accidents and incidents were reported to the nurse or manager on duty. Accidents had been recorded on an accident form and the registered manager told us that these were reviewed to identify any patterns or trends.

The provider did not have sufficient guidance for staff to follow to show how risks were mitigated when moving people. This was a breach of Regulation 12 (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We observed that one person's medicine was placed on the spoon with their meal. Staff did not inform them that they were being given their medicine. Medicine that has been agreed to be given this way should have a clinical record as to how to this decision had been made, what alternatives had been considered and should be reviewed on a regular basis. Staff were able to explain the rationale for this process as there was no information to confirm how this had been agreed and was being given in the person's best interest.

Medicine pots and syringes for drawing up liquid medicines were reused. There was no indication of how long they had been in use. One person had suffered from an infection through their PEG feed. (A 'PEG' is a Percutaneous endoscopic gastrostomy which is when a feeding tube is inserted directly into the person's stomach when they cannot maintain adequate nutrition with oral intake). The Home Enteral Nutrition (HEN) Service (Kent) had been involved and given guidance to staff recommending that the syringes used to push liquids through the PEG should be changed every week and rinsed with water only. There was no record to confirm that there was a system in place to make sure the advice had been implemented.

There was no epilepsy care plan in place for staff to give people their 'rescue' medicine if they had a seizure out in the community with the care staff. A clear individual protocol should be in place for each person to show trained staff how to give people this medicine should a person suffer a seizure. Care staff had not been trained to give people this medicine. When people went outside of the home the care staff took the medicine with them and in the event of a person having a seizure, were told to ring 999 in order that the person would receive their medicine by a trained health care professional. This could cause a delay in the person receiving their medicine in a timely manner.

The provider did not have an effective procedure in place to ensure that emergency medicine was available when needed. Staff were not following procedures about managing medicines, including those related to infection control. This was a breach of Regulation 12 (2)(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

There were guidelines in the care plan to show what signs people exhibit if they needed pain relief. One relative commented that staff knew their family member well and recognised that when they were not smiling, looking at them in their usual way, or making different sounds than usual, that they may require pain relief.

There were systems in place to reduce the risk of infections in the service, such as monthly cleaning schedules and

Requires improvement

# Is the service safe?

checks to monitor the standard of cleanliness in the service. There was alcohol gel dispensers located throughout the service. Toilets and bathrooms were clean and had hand towels and liquid soap for people and staff to use. People's rooms were clean, tidy and well maintained. Some of the carpets in the communal area were stained, and although staff had vacuumed, they looked unclean and dirty.

Staff training records showed that all of the staff had received training in safeguarding adults. Staff understood about different types of abuse and knew what to do if they were worried about the safety of anyone who used the service. They were aware of the whistleblowing policy and were confident that staff would report any concerns to the nurses or manager. Staff were familiar with the processes to follow if any abuse was suspected in the service and how to contact the local authority safeguarding team. Staff knew people well and were able to recognise signs through behaviours and body language if people were upset or unhappy. When incidents occurred which may need to be raised as a safeguarding alert, the organisation had followed the correct procedures to make sure people were safeguarded against the risk of harm. Staff were aware of the safeguarding policy and told us they would not hesitate to report anything if they felt people were not being treated properly.

The human resources department were responsible for recruitment. There were systems in place to recruit new staff. Prospective members of staff completed an application form and a telephone questionnaire was carried out to see they understood the types of needs of the people who used the service. Interviews were carried out involving human resources staff, together with a person's relative and a nurse. There were set interview questions to promote consistency and to ensure only suitable staff were employed. Appropriate checks were carried out, including obtaining a Disclosure and Barring Service (DBS) check, references and checking people's employment history by exploring and recording any gaps in employment. The DBS check helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. All nurses' registration (PIN) numbers were regularly checked to ensure that the nurse was on the active register of the Nursing and Midwifery Council (NMC).

There were mixed views from staff and relatives with regard to the number of staff on duty. Some staff told us they had completed lots of overtime to cover the rota, especially in times of sickness or to cover vacant hours. Relatives felt that at time activities or one to one time was compromised due to lack of staff. Two members of staff told us that at times there was a shortage of staff and people were 'owed' one to one time as there was not enough staff on duty to make sure everyone received their times.

At the time of the inspection there was sufficient staff on duty and an additional rota to allocate one to one staffing and all of the one to one time had been allocated. People were not rushed and were receiving the attention and care they needed.

Relatives were concerned that with so many new staff meeting the complex need of the people using the service would be difficult. The deputy manager told us that the new staff were accompanied by an experienced member of staff to monitor their skills and competencies. New staff members told us that the established staff had been very supportive and guided them until they felt confident they could meet people's needs. Staff had job descriptions and contracts so they were aware of their role and responsibilities, as well as their terms and conditions of employment.

The staff carried out regular health and safety checks of the environment and equipment. This made sure that people lived in a safe environment and that equipment was safe to use. These included ensuring that all of the moving and handling equipment, including the hoists were serviced and in good working order. People had special equipment to support their mobility needs, such as specially made wheel chairs, which were also checked and cleaned on a regular basis. Weekly checks were carried out on the fire alarms and other fire equipment to make sure it was fit for purpose. The garden was well maintained, with areas of decking where people could sit in the warmer weather. An Incident and Business Continuity plan was in place with clear instructions to staff about how to deal with emergencies such as fire or adverse weather conditions.

Requires improvement

# Is the service effective?

## Our findings

One relative told us they were satisfied with the service, they said "This is a brilliant home".

All new staff were taken through an induction. One nurse told us how they were working to improve the current induction as they were not entirely satisfied with the induction they had received. The human resources officer told us they were aware that the induction needed improving and did not follow guidance given by Skills for Care, which is the organisation recognised for the required standards for staff working in adult social care. They said that they were in the process of accessing the new skills for care certificate induction, so new and current members of staff would be supported to enhance their skills. The lack of a structured induction may leave new staff at risk of not providing people with the care they needed.

There were mixed views on the induction training process. Care staff told us that they felt the induction was informative, whilst nursing staff felt the induction had not been thorough enough.

Care staff confirmed that they shadowed more experienced members of staff on shift when they first started work. The induction for care staff covered mental capacity and deprivation of liberty, moving and handling, and infection control. There was also guidance on how to support people in the hydrotherapy pool. One member of staff who had never worked in the care sector before told us how the staff supported them very well and made sure they were confident with people before they took the lead in personal care. Nursing staff told us that they monitored new staff competencies but this was not recorded to confirm it had taken place. Staff received an assessment after three months of employment and a further assessment at six months, before they became permanent staff.

Nursing staff said: "I spent a day watching DVD's and had an introduction into home, then spent two weeks shadowing other nurses and was shown the day to day routines of the home". "I do not feel that the induction was appropriate and thorough, this was because it was not in depth. I only felt more confident as I was aware of people's complex needs. I was told to just read the care plans". "The induction was ok, but it doesn't really tell you about people's needs". "The two weeks shadowing was very good". "I felt that people's needs were not communicated during induction". "The care plans are complicated and not user friendly". "Just watching a load of DVD's isn't really helpful".

All staff had a personal training record and received regular training updates, which included moving and handling, health and safety, infection control, safeguarding adults, mental capacity, food hygiene and fire safety. Some staff had also received specialist training, such as epilepsy and communication. However not all staff had received specialist training such as diabetes, and training in specific syndromes of the people using the service. Continence care had not been updated since 2010. Some nurses had received Enteral Tube Training in 2014 and safe use of insulin in 2013.

There was a supervision list for both houses detailing which line manager was responsible for staff supervision. There were mixed views with the standard of supervision provided from the management to the nursing staff. Although new staff had received supervision on a weekly basis they felt it was more of a 'tick box' session and not in depth. New nursing staff told us that they had not received any clinical supervision and one established nurse said it had been a very long time since clinical supervision was provided. Another nurse said they had not been observed as competent when giving people their medicines to ensure they were giving people their medicine safely.

New care staff told us they felt well supported, although one member of care staff said they had not received supervision yet. A longer serving member of staff said they knew what the policy was (supervision should be provided to all staff three times a year) but had only received one supervision in three years.

There was an appraisal system in place but not all staff had received an appraisal meeting to discuss their on-going development and training needs.

People were not receiving care from staff that had regular supervision or appraisal to discuss and improve their practice in order to develop their skills and improve their practice.

The induction programme was not preparing staff for their role. Further specialist training was required to ensure staff had the skills to fulfil the requirements of their role. Supervision and appraisals for all staff was not being

# Is the service effective?

provided to make sure staff development and competence was maintained. This is a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Care staff felt well supported on a general day to day basis and felt the nurses gave them good advice. All staff attended monthly house meetings where they could discuss the running of the service and any concerns. They felt these were positive meetings and gave staff an opportunity to discuss any issues.

Staff had received on line training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). MCA protects people who lack mental capacity, and assesses their ability to make decisions or participate in decision-making. Staff demonstrated how they gained people's consent to giving them care and support. They told us people were able to respond with their eyes or by making gestures to let them know their feelings.

However, mental capacity assessments were generic as each assessment was not decision specific. All of the decisions for one person were listed on one form and had not been individually assessed. Each restriction of a person's liberty should be justified and measured against proportionality of the response to the potential risk of harm. There was no rationale as to why each restriction was in the person's best interest.

The service had made an urgent DoLS authorisation for seven days. The reason for the request was 'lacks capacity about being in a care setting and is not free to leave'. A standard authorisation was also being processed but there was no further information to clarify this was in their best interests.

One person's bed had restrictive high rails around the sides and front which could be locked. There was no mental capacity assessment or DoLS application relating to this equipment. There was no information of how this decision had been made or records to show that a meeting had been held to make sure this decision was in the person's best interest.

The provider has not acted in accordance with the Mental Capacity Act and associated code of practice. This is in breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Although some mental capacity assessments had not been completed, some decisions were made in people's best interests by people who knew them well. A relative told us how they had been involved in a best interest decision meeting which included the speech and language therapist so that the right decision would be made for their relative. Another relative told us how a best interest meeting had been made about their relative's dietary needs and the risk of choking. The health care professionals met and an alternative dietary regime was agreed and implemented.

People had access to health care professionals such as GP's, consultants, specialist nurses, dieticians, physiotherapists and speech and language therapists. People had regular appointments with chiropodists, dentists and opticians. However, care plans were not easy to follow and did not always have accurate information, for example a form in one care plan stated that the person was not having physiotherapy but in the care plan it stated that physiotherapy was happening. Another plan had photographs of a person's physiotherapy routine and how to carry this out. Staff told us that there was a record in the person's bedroom to show that the physiotherapy was taking place, however they could not find this information.

People living with epilepsy had care plans and charts in their plan to monitor their seizures. The amount of time and number of the seizures were being recorded, together with information such as 'make sure the person is in the recovery position, observe and follow the directive for the seizure and carry out the instructions'. Nurses were able to explain what the triggers were that might result in a seizure such as a high temperature, and pain, but this information was not recorded in their care plan.

The provider was not ensuring that person centred care and treatment was being provided to meet the needs of people using the service. This is in breach of Regulation 9(1)(a)

Specialist nursing 'profiling' beds were provided, which supported people with their care and comfort. Pressure relieving air mattresses, together with cushions, were in place to support people to maintain healthy skin. There were skin and pressure care plans which contained guidance for staff to follow to reduce the risk of pressure areas, including how people needed to change their position to keep their skin as healthy as possible. Care plans contained body maps and bruise charts which recorded and monitored people's skin conditions.

Requires improvement

# Is the service effective?

Relatives told us that they were kept updated with their relative's health, and had regular emails of telephone calls. Hospital and GP appointments were made if staff had concerns and the person's family were informed and sometimes attended appointments too. They said that they were involved in their relatives care and liaised with the health care professionals on a regular basis. They also said that staff knew when their relative was unwell and on one occasion when it was revealed their relative did not have an infection staff knew they were unwell and eventually the person was diagnosed with pneumonia. They felt staff knew the people well and made sure they received the medical attention they needed.

People's dietary needs were monitored and provided in line with support from dieticians and speech and language therapists where appropriate. Care plans had risk assessments in place for individual choices and preferences with regard to eating and drinking. People's weights were recorded and any significant changes were reported to senior staff for action and referral to a health care professional. Where necessary fluid and food charts were in place to monitor that people were receiving the food and drink they needed.

Due to people's complex dietary needs the agency chef was being supported by a permanent member of the staff to ensure that all specialist dietary needs were provided. The chef was also liaising with a relative and using menu suggestions they had proposed so that people received a varied diet.

We observed people eating their lunch. One person had his food cut into small pieces and was able to eat using a spoon, and was helped by staff when necessary. Another person had their food mashed and was supported to eat by staff. Staff offered a drink between mouthfuls and talked to them. One person was refusing to eat their meal and after a few tries the staff offered them chocolate mousse. This was also refused. Staff told us that they would get another member of staff to try and if this was not successful the person was usually offered meal supplements to ensure they received the nourishment they needed.

The premises had been built to meet the physical needs of people. There were ceiling track hoists in each bedroom and bathroom, specialised baths, moving and handling equipment, wide corridors for people who used wheelchairs, and ramps. There was also a range of crockery and cutlery designed to meet people's individual needs.

A day centre, sensory room, computer room, art room and hydrotherapy pool facilities were also available. There was a sensory garden with decking and raised beds. The garden and decking was easily accessible to people, and was well maintained.

In the service there were different types of seating so that people with different physical and mobility needs had somewhere comfortable to sit. There was a large single swing chair (known as a helicopter chair). There were comfortable lounge style couches and large tables with chairs and room for people to use their wheelchairs to sit at the table. There were crash mats and bean bags when people wanted to relax in different positions.

People's rooms were well decorated and had hoists, appropriate beds and mattresses and personal possessions. Some of the larger individual equipment like wheelchairs, walkers and standing frames could not be accommodated in the rooms so were kept out in the corridors or in the communal bathrooms.

Good

# Is the service caring?

## Our findings

Relatives told us the service was caring. They felt the staff would go and had gone the 'extra mile' for people, such as, staff stayed overnight with people when they went to hospital and staff who were off duty on Christmas day would call in with presents for people.

All staff demonstrated a commitment to people. Staff told us the service was a very caring place. They told us they looked forward to coming to work; they came in early and left late and helped out in their own time because: "These guys are the heart of the home". "This is a special place. It gives you a real passion and fire for people who live here".

Staff knew how to offer people choices. They talked about offering meals, choice of DVD films, helping people when they wanted to go to their room or go out into the garden. Staff talked about how people helped choose the shopping. On the day of our inspection staff supported people to talk about the shopping list and asked people if there was anything they wanted.

People's bedrooms were personalised with their photographs and what was important to them. Staff upheld people's choices and preferences, one relative said: "My relative's room was designed around them".

There was a relaxed and friendly atmosphere at the service. People looked very comfortable with the staff that supported them. Staff chatted to people and spoke with individuals quietly and supported them with their daily needs. People smiled when staff touched their hands and responded with smiles and gestures.

People were encouraged to communicate with books and sign language. Staff were seen talking with people using their preferred method of communication. Staff were patient and gave people time to respond to them. They spoke about respecting people's rights and supporting them to maintain their independence and make choices.

Staff said: "We get to know people on a personal level which means we know about their likes and dislikes and that means we can give them the support they need". "It's about communication. You need to be at eye level so you can make contact". "Different smiles mean different things and when you know them you can understand what these are and what they are for".

Most people had family members to support them when they needed to make complex decisions, such as coming to live at the service or attending health care appointments. Two relatives mentioned that the staff would advocate for their relatives, for example when doctors requested that the person went to the surgery, when they needed to receive a 'home call'.

Advocacy services were available to people if they needed independent support to make decisions.

People's privacy and dignity was respected by staff. When staff wished to discuss a confidential matter with a person they spoke to them in private. Staff were very good at maintaining people's privacy and dignity, for example in the hydrotherapy pool a relative told us that another relative was politely asked to move back by staff to protect a person's dignity. Another relative said. "My relative is always beautifully clean, and staff take care with their appearance".

Staff were aware of people's religious choices and different backgrounds. Staff respected people's beliefs and supported them to live how they wanted to.

People were encouraged to be as independent as they could. One care plan stated what a person could do to remain as independent as possible, for example how staff should support them to push their arms through the sleeves of their jumper.

Staff were attentive and kind. One person experienced a seizure and staff immediately sat down beside them, held their hands gently and spoke to them in a reassuring manner until they were able to recover.

We saw one person who was blind being supported by a member of staff. They sat beside them speaking with them and interacting with their favourite music until they relaxed and we could see them moving around enjoying the music. We later saw this person in their room having time out with their music and soft lights relaxing on their bed.

Visitors were welcome in the service. Some relatives visited the home on a daily basis. One relative said: "The staff know my relative well and we have regular weekend home visits".

Requires improvement

# Is the service responsive?

## Our findings

Relatives said that the service was responsive to their relatives changing needs. A relative told us that they had informed staff that their relative's mobility was reduced when they were tired. The next day a staff member told them how they had noticed this before and had made sure the person used a wheelchair when they needed to. The relative commented: "This shows that the staff have been taking things on board and they keep us informed". All of the relatives spoken with said they were involved in the assessments and care plans of their relatives.

Care needs assessments were carried out when people came to live at the service. However, some of the information from the previous service had not always been included in the care plan. Care plans varied in the amount of detail and information they contained. Some support plans were less centred on the person than others. Some care plans were written in a way that was difficult for staff to find the information they needed to give the right care and support in the way that people preferred.

Each care plan had a profile of the person, their individual needs assessment, health care plans, social/educational care plans, professional correspondence, dairy of important dates and property notes. There was also another folder with various documents such as a bruise pathway, emergency profile, daily and clinical notes. The third folder was a communication passport, with nursing assessments and current medicines, etc. The amount of information in the folders was hard to follow, not always clear and lacked guidance to show staff how to meet people's needs. For example, in one person's eating and drinking plan it had details of their dietary needs and stated that their bed needed to be tilted to minimise the risk of aspiration. There was also a risk as this person was prone to vomiting and choking. The guidance for staff stated 'that the person had a significant risk of choking and please refer to the choking policy'. It was noted in the care plan when the person had vomited but it did not record what action had been taken and there was no other guidance to support staff to minimise the risks and support this person safely.

One person's plan stated 'needs help with all personal care', but there was no details of what help and support they needed in line with their choices and preferences. In their communication passport it was recorded that the person did not have any verbal communication and used facial expressions to staff to express their needs, however there was no explanation for staff to show how to interpret these. The plan also said that the person had behavioural changes, it was noted 'please take steps to ensure support required is immediate and appropriate', but did not say how these should be managed or give staff guidance of how to support the person in the best way.

Some staff felt that the care plans were poorly written and hard to negotiate. Staff said: "The care plans do not make sense". "Could not make head or tail of them". "The care plans are awful. If someone could show someone how to write them they would deserve a Nobel prize".

Although some care plans had been reviewed not all of them were up to date, for example one plan had not been updated to show how a person's sleep routine had changed, some physiotherapy notes were not up to date to confirm what programme was in place, a dietician had recommended that a person be weighed regularly and the plan had not been updated and one moving and handling risk assessment had not been updated since 2014. Staff knew people well and were able to explain people's individual needs but this was not reflected in their records. The lack of detailed records poses a risk to people as new or agency staff may not have the knowledge to care for people in line with their personalised care needs.

The provider was not ensuring that person centred care and treatment was meeting the needs of people and plans had not all been regularly reviewed or updated. This is in breach of Regulation 9(1)(a)(b)(c), 9(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Although not all care plans had been updated and reviewed, verbal daily handovers from senior staff took place at the beginning of every shift. We observed that each person's daily needs, their health care, personal care or concerns were discussed with staff at length so that staff were up to date with people's current needs. Staff told us this helped them to deliver the care people needed. They told us that the nurses were available for guidance and responded to people's changing needs. A relative commented: "They keep a record of what my relative eats and drinks so at handover the new shift know the situation. It is good information for us relatives as well".

There was a new format of care planning being introduced but the implementation of the 'Active Support Plan' was

Requires improvement

# Is the service responsive?

slow. Active support plans should be easy to understand to support people to have involvement in their care and daily lives. Staff told us that this concept of care planning had been introduced some time ago but progress was slow as only one person had an active care plan in place. The plan had been completed and contained pictorial information of how to engage in all of their needs including daily tasks and activities. There were goals to achieve and this person was being supported to manage each task over a period of time. They had achieved one of their tasks, which was clearly recorded in their plan. The service had appointed an Active Support Practising Skill Mentor to support the new planning process. There were no timescales in place to confirm when this process would be completed.

There were planned activities and one to one sessions for all of the people living at Martha House and Frances House. A relative told us how the staff took their relative for walks and used the hydrotherapy pool three times a week as well as attending sensory sessions in the day centre.

People were offered the opportunity to join in a variety of social activities. The activities included membership of local groups and clubs, gardening, outings in the local community, music therapy, painting, the hydrotherapy pool and day centre. The statement of purpose informs people that Martha Trust has a Christian ethos and aims to support people in their beliefs. There were regular prayer meetings and the service was supported by the local vicar. There are also some church led groups in the community should people wish to attend.

Special therapeutic therapies were also available, such as aromatherapy, reflexology, and a large touch screen computer. There were two people playing a game with two members of staff popping balloons. Another person had their iPad which they used to speak with their parents every day.

The sensory room was used to create an environment which was relaxing and calming for people through the use of music and soft lights. Staff said, currently only one person was using this on a daily basis, but the room was 'still in the process of being developed further'.

People were also support to take part in sensory cooking in Frances House. There was a section in the kitchen which was adapted so people could take part in sensory cooking. Staff told us that this was about 'tastes and smells'. The garden has been designed with raised beds to encourage people to enjoy the experience of gardening.

People were able to attend the day centre which was located within the grounds of the service, and were also supported to go out and have meals in the community.

All of the relatives spoken with felt comfortable about raising concerns knowing that the response would be open and honest. Staff felt confident to pass complaints they received to the registered manager or nursing staff. When complaints had been made these had been investigated and responded to appropriately. The service had a written complaints process that was written in a way that people could understand. There was no other format for people to be supported to complain, such as a pictorial complaints procedure. The complaints procedure was on display by the visitor's book so visitors can access this easily. There had been three complaints this year. People were written to on receipt of a complaint to acknowledge their complaint. All complaints received have been addressed within the 28 day timescales. Records showed that all complaints have been resolved satisfactorily.

Requires improvement

# Is the service well-led?

## Our findings

Relatives said: "I would definitely recommend this service". The service had created "a good atmosphere." My relative is "really happy there".

The service had a registered manager in place who was supported by a deputy manager, nursing and care staff. There were also human resources and administration staff within the complex. The registered manager was not available at the time of the inspection and the deputy manager was in charge of the service. Staff told us that the registered manager was available and accessible; however they were not all entirely satisfied with the support received.

There were mixed comments from staff and relatives about the support from the registered manager. One relative told us that the registered manager was dedicated and kept them informed about their relative either by telephone or email. However, other relatives felt the manager was not always visible throughout the service. They did not feel confident that the management of the service was strong to make sure people and staff had the confidence that the service was well led.

One member of staff said that the manager was visible in the service and sometimes walked around the two locations. Other staff felt that the registered manager should spend more time in the service to instil confidence amongst the staff and provide more effective leadership of the service.

There were systems in place to monitor the quality of the service. There were audits in place to check the quality of medicines, care planning, infection control and health and safety. These also covered housekeeping, the kitchen environment, hand washing and checking the first aid kit.

Although some of the actions identified from the audits had been completed the care plan audit identified several areas of improvement which had not been actioned. For example, the audit for the care plans dated 13 March 2015 identified shortfalls in completing documents, consistently completing the care plan entries, and the lack of detail in the risk assessments. The timescale to achieve these improvements was within a month of the date of the audit. At the time of the inspection these shortfalls had not been addressed two months later. There was no explanation as to why the shortfalls had not been addressed.

Senior staff had not received clinical supervision and did not feel that the registered manager was visible within the service. Staff told us that this did not make them feel supported with the day to day running of the service. Care staff supervision and appraisals were not up to date to support staff to fulfil their role.

Accidents and incidents had been recorded, however there was no record of any summary of the events to help ensure appropriate action was being taken to reduce the risk of further or similar occurrences.

Records were not accurate and completed properly. Care plans did not show what person centred care was in place and did not always reflect the care being provided. There was a lack of documents being signed or completed. For example, some care plans did not have a full personal history sheet completed. People's healthcare appointments and the outcomes were not always recorded. We noted one person's outpatient appointment cancelled in January and there was no record of when this was rebooked. The person saw a consultant in April 2015 but records did not show why and if this replaced the original appointment. Charts to monitor daily dietary needs and other health related charts had not been completed fully or documented consistently.

The provider sought the views of relatives by holding regular family forums where relatives had the opportunity to voice their opinions of the service. Minutes showed how open discussions took place with regard to equipment, redecoration of the service, fundraising and forthcoming events There were also regular house meetings with people and their key workers to discuss the care being provided. There was no other system in place to actively seek the views of a range of stakeholders, staff, or visiting professionals which should be used to drive improvements to the quality of the service.

The trustees of the organisation also met on a regular basis, however there were no systems in place to show how they monitored the continuous improvement of the service.

The systems in place to quality assure the care being provided were not effective. Feedback was not being gathered from all stakeholders to improve the quality of the

Requires improvement

# Is the service well-led?

service. Records were not completed properly or accurately. This is a breach of regulation 17(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The deputy manager, nursing and care staff demonstrated a good knowledge of the people and the service. Staff told us that on occasions the deputy manager covered shifts in the service providing direct care. Staff were clear about their roles and responsibilities and the staffing structure ensured that they knew who they were accountable to.

One relative felt the service was open and transparent, as the staff informed them of a medicine error and what action the staff had been taken. They said that the staff continued to make frequent contact with the family to reassure them that there was no adverse reaction to their relative. They said that they understood that mistakes happen and felt the service had been good and honest.

Our observations and discussions with people, staff, and visiting professionals showed that there was an open and positive culture between people and staff. The organisations visions and values were on display, which included treating everyone with dignity and respect, supporting and encouraging, we show compassion to everyone at the service and to each other. Staff were aware of this ethos and spoke about people in a dignified manner. They stressed the importance of treating people with dignity and respect, whilst respecting people's personal wishes and beliefs. They told us that they worked well as a team to provide the people with a good quality of life.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. The service understood their responsibility and had sent all of the statutory notifications that were required to be submitted to us for any incidents or changes that affected the service.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>The provider did not have sufficient guidance for staff to follow to show how risks were mitigated when moving people.<br><br>The provider did not have an effective procedure in place to ensure that emergency medicine was available when needed in a reasonable time without posing a risk.<br><br>Staff were not following procedures about managing medicines, including those related to infection control.<br><br>Regulation 12 (2)(a)(b)(f)(g) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>The induction programme was not preparing staff for their role.<br><br>Further specialist training was required to ensure staff had the skills to fulfil the requirements of their role.<br><br>Supervision and appraisals for all staff was not being provided to make sure staff development and competence was maintained.<br><br>Regulation 18(2)(a) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br><br>The provider has not acted in accordance with the Mental Capacity Act and associated code of practice.<br><br>Regulation 11(1). |

This section is primarily information for the provider

# Action we have told the provider to take

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>The provider was not ensuring that person centred care and treatment was being provided to meet the needs of people using the service.<br><br>The provider was not ensuring that person centred care and treatment was meeting the needs of people using the service and plans had not all been reviewed or updated.<br><br>Regulation 9(1)(a)(b)(c), 9(3)(a) |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>The systems in place to quality assure the care being provided were not effective.<br><br>Feedback was not being gathered from all stakeholders to improve the quality of the service.<br><br>Records were not completed properly or accurately.<br><br>Regulation 17(2)(a)(b)(c) |