Martha Trust

Martha House

Inspection report

Martha Trust
Homemead Lane
Deal
Kent
CT14 0PG

Tel: 01304615223
Website: www.marthatrust.org.uk

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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

Summary of findings

Overall summary

This inspection took place on 5 and 6 October 2017 and was unannounced on the first day and announced on the second day.

Martha House provides nursing and personal care and accommodation for up to 23 young adults with profound and multiple learning and physical disabilities. There were 20 people living at the service and one person on respite care during the inspection. There were 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 are spacious, with hoist systems in place. There is parking available on site, and there are other facilities in the complex, including a hydrotherapy pool.

There was no registered manager in post. An acting manager had been appointed recently and was leading the service. They had not yet applied to be registered with CQC. A registered manager is a person who has 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. We were supported during the inspection by the manager, deputy managers- one based in each house and clerical staff.

Potential risks to people's health and welfare had not been consistently identified. Risks that had been identified did not always have detailed guidance for staff to manage risk safely. This led to a risk of people not receiving support that was safe and effective. Accidents and incidents had been recorded and investigated to look for patterns to help prevent them from happening again.

Staff received training appropriate to their role. Checks on the environment had been completed but shortfalls had not always been identified and rectified to keep people safe.

People were not protected from the unsafe management of medicines. People did not always receive their medicines when they needed them. Medicines were not recorded or managed safely. Before the inspection, medicines errors had been identified that put people's health and welfare at risk. The provider had taken action however, shortfalls were found at this inspection.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires, that as far as possible, people make their own decisions and are helped to do so when needed. When they lack the mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff sought consent from people before providing support. However, senior staff had not followed the principles of MCA when making decisions about people's care and support. Decisions such as the use of

bedrails had not been consistently recorded in line with the guidelines of MCA and not all decisions that people were unable to make on a day to day basis had been considered and recorded.

Staff had not received one to one supervisions in line with the provider's policy. Staff told us that they felt supported by the deputy managers but there were mixed views on the overall communication within the service. Some staff and relatives felt that the communication could be better and there was not an open culture, others were very happy and felt that they were kept informed.

There were plans in place for monitoring the quality of the service. Audits completed by staff at the service were not effective and had not identified the shortfalls found at this inspection. The provider told us that they completed audits every six months but these had not been completed since May 2016.

Each person had a care plan that had information about the person's life and preferences. The care plans did not always contain details for staff to give person centred support, were not up to date and had not been consistently reviewed. The service employed agency staff on a regular basis and there was a risk that without clear up to date care plans, people would not receive support as they preferred. Records were not all accurate and up to date.

Relatives told us that staff genuinely cared about the people they supported. People seemed to be happy and relaxed with staff and enjoyed being each other's company.

Staff knew how to keep people safe from abuse. The management team raised safeguarding alerts when required, but there had been a delay in raising one alert. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. CQC check that appropriate action had been taken. The management team had submitted notifications.

Staff were recruited safely. There were mixed views about whether there were sufficient staff on duty. Some staff told us that the need for one to one support for some people and staff sickness meant at times staffing was stretched. The manager told us that they reviewed staffing according to people's needs. During the inspection there were sufficient staff on duty.

Before the inspection, concerns were raised that people had not been referred to health professionals as quickly as they should have been. Records showed that people had been referred to healthcare professionals promptly when needed. People were supported to eat and drink to maintain good health. People who were unable to take nutrition orally were supported by staff trained appropriately.

People were supported to attend activities. People had personalised activity plans. Relatives told us that they knew how to complain. The service had received eight complaints in the last year, the complaints procedure had not always been followed.

Surveys had been sent out to relatives, staff and stakeholders to obtain their views about the service. The results of the staff survey had been analysed. There were no results for the relatives and stakeholder survey as they had only just been completed at the time of the inspection.

Staff understood their roles and responsibilities and shared the provider's vision of a good quality service. Relatives were invited to a relative's forum and there were family representatives who put forward any concerns or suggestions to the provider. Staff had regular staff meetings to give their opinions and raise any concerns.

Providers are required, by law, to display their CQC rating to inform the public on how they are performing. The latest CQC rating was displayed in the service and these details were also on the provider's website.

We found two 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.

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.

Potential risks to people's health and welfare had not been consistently assessed. There was not always detailed guidance for staff to follow to mitigate risk.

People were not protected from the risks of unsafe management of medicines. People did not always receive their medicines as prescribed.

Staff knew how to recognise signs of abuse.

Staff were recruited safely. There were sufficient staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the Mental Capacity Act 2005 had not been consistently followed in making and recording best interest decisions.

Staff had not received supervision in line with the provider's policy. Staff had received training for their role.

People's healthcare needs were monitored and supported.

People had enough to eat and drink.

Is the service caring?

Good

The service was caring.

People and their loved ones told us staff were caring.

Staff communicated with people in the way they preferred.

People appeared happy and relaxed in the company of staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not consistently contain detail for staff to provide support as people preferred.

Care plans had not been consistently reviewed and did not always contain up to date information.

The complaints procedure had not always been followed.

People were supported to take part in a variety of activities.

Is the service well-led?

Requires Improvement

The service was not well led.

There was no registered manager.

Audits had not been completed consistently. Those completed had not highlighted the shortfalls found at this inspection.

Records were not all accurate.

Notifications had been submitted to CQC in a timely manner.

Relatives, staff and stakeholders had been asked their opinion of the service.

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 5 and 6 October 2017and was unannounced on the first day and announced on the second day.

The inspection was prompted in part by information shared with CQC from other health and social care professionals and others. The information shared indicated potential concerns about the management of risks and people's health care needs. This inspection examined those risks.

The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has experience of caring for someone who uses this type of service.

Before the inspection we asked the provider to complete the Provider Information Record (PIR). The PIR is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We reviewed the records we held about the service, including details of any statutory notifications submitted by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

We spoke to three people's relatives, three nursing staff and four care staff, the chef, the deputy managers, human resources staff, the acting manager and the chief executive of the Martha Trust. We observed staff carrying out their duties, communicating and interacting with people. We completed a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We reviewed five people's care plans and risk assessments, medicines records, ten staff files, training information and checks and audits. We spoke with two health and social care professionals during and after the inspection.

We last inspected Martha House in July 2016 and the service was rated Good overall.

Requires Improvement

Is the service safe?

Our findings

People appeared to be relaxed and happy in the company of staff. One relative told us, "This is the best place for my (relative)."

Risks to people's health and welfare had not been assessed and identified consistently. There was not always detailed guidance for staff to follow to mitigate risk and keep people as safe as possible. The risk assessments for people living with epilepsy varied in detail. For one person there were details about how the person presented when having a seizure, how staff should support the person during the seizure and the protocol for medication during the seizure. For other people there was limited information about how the person presented during a seizure and what support they should receive. Staff told us how they supported people during and after a seizure to maintain their safety but the records that staff and temporary staff needed to follow did not reflect this.

One person vomited after a seizure and the seizures were often un witnessed by staff, increasing the risk of aspiration or choking. The risk of the person vomiting following a seizure had not been assessed. No guidance was in place for staff to reduce the risk of this happening and what action to take if the person showed signs of aspiration. The deputy manager told us that people had not aspirated or choked so a risk assessment had not been put in place. They agreed to do this following the inspection.

Some people were at risk of developing urinary infections, an infection could increase the amount of seizures people experienced. The risk of urinary infection had been identified and for some people there was guidance in place for staff to follow about what signs and symptoms to look for, how to prevent infection and what action to take if they thought the person may have an infection. Staff told us that they would inform the nurse if they felt people were unwell and sleepy. The provider agreed there needed to be consistency in guidance and was working to do this.

People who needed support to move safely had detailed moving and handling assessments. Staff had guidance about how to support people safely when moving them in all situations. However, there were five incidents reported to the provider when staff had not followed the guidance in place and had put people at risk as people had not been moved safely. The staff involved in the incidents had been retrained and their competency checked and there had been no further incidents. During the inspection, staff moved people safely around the building.

The provider had failed to assess all risks and to have sufficient guidance for staff to follow to show how risks were mitigated when managing health conditions and health and safety. The provider had not ensured that guidance was followed to keep people safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected against the risks associated with the unsafe use and management of medicines. There had been a number of medicines errors by nursing staff that were employed by the provider and agency nurses, people had not received medicines as prescribed, including anti seizure medicines.

Following the inspection, the provider told us that nurses now checked medicines had been signed for at the handover of shifts.

People living with epilepsy were prescribed 'as and when' medicines to control their seizures. There were detailed protocols in place for staff to follow about how to support people living with epilepsy. However, people were also prescribed other medicines on a 'as and when required' basis. There were no guidelines for staff to follow about when to give these medicines, how often and what dose. For example, one person was prescribed Hyoscine Butylbromide 10mg two tablets, three times a day as needed. There are several reasons why a person would be prescribed this medicine including for stomach pains, there was no guidance for staff about what symptoms this medicine should be given for and when an additional dose should be given if the initial dose was not effective. There was a risk that the person may not receive medicine when they needed it.

Most medicines were ordered each month, medicines that are prescribed on an 'as and when' basis may not need to be ordered regularly. It is best practice for the balance of medicines in stock to be 'carried forward' to the next medicines administration record (MAR) chart so that staff know when they need to order more stock. This had not been completed and there was a risk that people would not have sufficient stock of medicines when they needed them.

At the inspection, we found that a pain patch had been administered a day early as the date for administration had not been checked. This was a records issue as the person suffered no ill effects. Some instructions had been hand written onto the MAR chart. It is best practice for the instruction to be signed by two staff to confirm it is correct. Handwritten instructions had not been consistently double signed to confirm they were correct and reduce the risk of errors.

There were no guidelines for staff to follow when applying creams to people. Care staff did not have an administration chart to sign to confirm that they had applied the cream as prescribed. The daily records showed that staff had recorded when they had applied cream, but were not clear about where the cream had been applied.

The provider had failed to protect people from the unsafe management and administration of medicines. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us and records showed that staff had received training on how to safeguard people from harm and abuse and staff knew how to contact outside agencies if they were concerned. Staff were confident that they could raise any concerns with the nurse or deputy manager and appropriate action would be taken.

The provider had policies and procedures in place to ensure that any incidents would be raised as a safeguarding alert when required. There had been concerns before the inspection that the provider had not raised one safeguarding alert quickly. Following an investigation by the local safeguarding authority, it was found that staff had waited two weeks before they brought concerns to the provider. The provider told us that they were investigating the incident and would take action to ensure that it did not happen again.

There were plans in place to manage people's money safely. Senior staff had access to monies, there were receipts kept for all monies spent and each person's money was kept separately.

Staff were recruited safely. Staff told us that new staff now had their photograph taken on their first day, staff had their identity checked. The human resources department were responsible for recruitment. Staff

files included application forms, records of interview and references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. All nurses' registration (PIN) numbers were checked regularly to make sure they were still current.

There were mixed views from staff and relatives about the number of staff on duty. There had been concerns raised that people were not receiving the one to one support time as agreed by their funding authority. Staff explained that they were not specifically allocated to provide one to one time with people, this was decided at each shift. They said that some people had complex needs and required two staff to support them with their personal care, staff told us that they could only give one to one time when everybody was up. Staff told us that the one to one time was not always planned and could be compromised as there were other demands on staff time and if staff sickness was not covered. The manager told us that the number of staff on duty reflected the number of staff needed to provide one to one time.

During the inspection we observed that there were sufficient staff on duty to meet people's needs. Some people were attending activities and out with their families. The people remaining did not appear to be rushed and were receiving the attention and one to one support they needed.

Before the inspection concerns had been raised that the service was dirty and infection control protocols were not being followed. The manager had completed an infection control audit on 31 August 2017 and identified shortfalls in the cleanliness of the service. Following the audit the provider had employed agency cleaners to bring the level of cleanliness to the required standard. During the inspection all areas of the service were clean.

Each person had a personal emergency evacuation plan (PEEP) in place, so that people could be safely evacuated from the building in the case of an emergency. There was a fire risk assessment in place and regular checks were completed on fire equipment. Staff completed regular health and safety checks of the equipment including hoists to ensure they were in good working order to keep people safe.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive possible.

Mental capacity assessments had not been consistently completed, were not decision specific and decisions made in peoples' best interest had not been recorded. MCA assessments had not been reviewed since 2015 to check whether people's capacity had changed. The wording of the completed documentation did not reflect current best practice. For example, an MCA assessment about the use of bed rails had been completed for two people, both stated that the person needed to be 'restrained' while in bed when this was not the case. People required bedrails to keep them safe while they moved around the bed freely.

Assessments for the need for bedrails were not consistent. The assessment had been completed by one member of staff rather than by staff and others who knew the person well. There was no record of how the decision had been made and whether it was in the person's best interest. For another person there was an assessment that others had been involved in and this recorded who, why and how the decision had been made in the person's best interest.

Some people were unable to make decisions about their safety or health care needs. Complex decisions, for example how to keep people hydrated when they were unable to take oral fluids, had been documented and made by people who knew them well. However, everyday decisions such as how to keep people safe and well had not. For example, some people had medicines prescribed to be administered in quite an invasive way. There was no record to show the rationale for these decisions, who had been involved and if other forms of medicine administration had been considered.

During the inspection, people did not appear to be restricted and were able to enjoy activities safely. Staff had received training in MCA. Staff told us how they gained people's consent to make day to day decisions, by speaking and through non-verbal communication. Staff knew people well and understood the way people communicated so they could offer choices in a meaningful way.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under MCA. The application procedure for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. Applications for DoLS had been made when required in line with guidance.

Staff had not received one to one supervision in accordance with the provider's policy to discuss their practice and their development. The manager told us that they were aware of this and were putting together a plan to rectify the situation. Staff told us, "Staff have daily communication but supervision needs improving."

When staff began working at the service they completed an induction. New staff shadowed experienced colleagues to get to know people, their preferences and routines. Staff completed essential training such as moving and handling, fire awareness and safeguarding. There was a three month and a six month evaluation when staff competencies were assessed. Staff confirmed that these meetings had taken place. Staff completed regular updates to their training including mental capacity and health and safety. and there was a training plan to ensure any updates due were arranged. Staff received specialist training such as epilepsy that was specific to people living at the service. The provider told us that they would soon be working with Skills for Care on a new programme of training for care staff. Registered nurses received training appropriate to their role. Two nurses were about to start a six month end of life course being provided by the local hospice.

During the inspection staff were seen putting their training into practice in areas such as moving people safely and nurses administering medicines. Before the inspection, there had been concerns raised to CQC and the provider, where staff had not adhered to best practice in regards to moving and handling people and medicines administration. In response, some staff had received additional training, but the competency of other staff had not been checked to assess their skills and knowledge. The provider told us that they were planning to complete competency checks.

A concern had been raised by relatives and social care professionals that people had not been referred to healthcare professionals in a timely manner. We followed this concern up and records reviewed at the inspection showed that staff had referred people promptly when needed to health professionals.

An agency member of staff had not followed the protocol for administering epilepsy medicines and for referring people to the emergency services. There had been a lack of communication between the agency staff and nursing staff employed by the service and this was still being investigated by the local safeguarding authority.

Staff recorded when people were seen by other healthcare professionals such as epilepsy specialists, chiropodists, dentists and opticians. Staff had referred people to healthcare professionals if their health needs changed including speech and language therapists (SALT) and to the dietician. Specialist nurses gave support when required, during the inspection, staff were supported to change people's feeding tubes by the specialist nurse.

Nutritional assessments were completed to make sure people were receiving the nutrition they needed. Some people had complex nutritional needs and had been involved with health care professionals to ensure they received a healthy diet. People had food that was especially prepared for them. The texture and consistency of people's food varied depending on their needs.

There was a new menu for both lunch and tea. There was only one choice offered for both meals. The chef told us that the menu had been devised to provide a balanced diet. There were a range of vegetarian meals included. The chef told us that there would be another option available if people did not like the meal provided and that staff informed the kitchen staff if people did not like a meal. People and their relatives had not been involved in the development of the menu and vegetarian meals had not been requested. People's involvement in the menu planning is an area for improvement which the provider had identified. Meetings had been arranged with people and their loved ones, as well as a dietician, to review the menus. People were offered drinks and snacks throughout the day by staff.

Some people were unable to eat and drink, and they received their nutrition through a PEG tube. A 'PEG' is a Percutaneous endoscopic gastrostomy which is when a feeding tube is inserted directly into the person's

stomach. Nursing staff ensured that people received the nutrition that had been prescribed by the Home Enteral Nutrition team, to keep people as healthy as possible. The care of the PEG tube was managed by nursing staff. Any concerns had been referred to the relevant health professional, for example, treatment had been received from the GP when a PEG site infection was observed.

We observed the lunchtime meal and staff were supporting people to eat. Staff spoke to people as they supported them to eat. People received meals that met their complex needs and were supported to be as independent as possible while eating.

Good

Is the service caring?

Our findings

People indicated that they thought the staff were caring and that they liked being in their company. People appeared to be relaxed in their home environment and with the staff that were providing support. Relatives told us that the staff were committed to people and thought that staff genuinely cared about people. Staff told us that they supported people to be as active as possible and have control of their lives as much as possible. Comments about staff in the provider's compliments log read 'thank you for the wonderful care and thoughtfulness' and 'staff are friendly well-mannered and welcoming.'

People's bedrooms were personalised with their photographs and items that were important to them. People's bedrooms reflected their personality and any equipment that might be needed was stored discreetly to protect people's privacy.

Staff communicated with people in ways that they understood. Staff were seen talking with people using books and sign language. People were given time to respond to staff. There were pictures around the building so that people knew where they were going and what was going on. People were shown items and what to do with them, for example musical instruments. People were smiling and giggling at the noises the instruments made. People were offered different textured materials to touch and hold, people appeared to enjoy this, they were smiling.

People seemed happy and relaxed with staff, there was a cheerful atmosphere at the service. People appeared to enjoy being each other's company and spent time together. Staff spoke about respecting people's rights and supporting them to make choices and be as independent as possible. Staff encouraged people to eat by using 'hand over hand' method, by placing their hands over the person's, the person is supported to eat.

Staff were respectful to people and to each other and feedback from people and relatives confirmed this. We observed one occasion when staff were not sensitive that others were around and might hear that they were talking about people. The provider agreed this was not acceptable and would address it straight away.

Staff knew people well and their likes and dislikes. There was a keyworker system in place. A keyworker is a named member of staff that was responsible for making sure people's needs were met. Staff respected people's decisions, staff understood and responded to people's cultural and spiritual needs.

Relatives told us that they were able to visit whenever they wanted and people were able to, where possible to stay with their relatives and go out for trips.

Personal, confidential information about people and their needs was kept safe and secure. People who needed support to express their views were supported by their families. If people required support from an advocate this was arranged. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us that people were supported with their day to day care needs and that staff kept them informed of changes.

Each person had a care plan that contained a profile of the person, their individual needs assessment, health care plans, professional correspondence and property notes. A second folder contained the daily routine people preferred and daily notes that care staff completed.

Care plans were not always detailed or up to date. Care plans in Martha House had been written in July 2016 but had not been reviewed until June 2017. The reviews had not identified if any changes needed to be made or if the care plan had been effective in meeting the person's needs. The deputy manager told us that the care plans should be reviewed monthly.

The care plans contained information about when people liked to go to bed and when they liked to get up. However, care plans would benefit from having more detail information for example, people's care plans stated, 'two people to give personal care', there was no details of what help and support people needed and what the support looked like in line with their choices and preferences. Throughout the care plans we looked at, there was limited detail about how to support people in the way they preferred. Care plans stated 'check people regularly' there was no guidance about what the term 'regularly' meant for that person. Care plans stated 'Check regular intervals throughout the night, regular position changes.' Staff did not have instructions on when to check each person to ensure they were safe and how often to change their position to keep their skin healthy. This would alter according to each person's needs.

Some care plans did have details about how to give support to people, however, daily notes showed that the support had not always been provided. The deputy home manager told us that the support was no longer given as people's needs had changed. One care plan stated the person should be supported to use the bathroom after each meal. The deputy home manager told us that the equipment was not appropriate for the person and the person was now supported in a different way. Another care plan said the person required suction therapy following meals. Records showed this had not been completed, staff told us that the person now had different meals and no longer required suction therapy. The care plans were not accurate and up to date, staff who did not know people well would not have detailed guidance to support people safely. The provider had employed a quality assurance administrator whose role included reviewing and updating daily records.

Most 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 posed a risk to people as new or agency staff may not have the knowledge to care for people in line with their personalised needs.

The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although not all care plans had been updated and reviewed, staff attended verbal daily handovers from senior staff, these took place at the beginning of each shift. Staff told us these handovers helped them to keep up to date with any changes in people's support.

There were planned activities and one to one sessions for all people living at the service. People were offered the opportunity to join in a variety of social activities, including sailing and carriage riding. There was an activities centre at the service, this included a music room, sensory room and a hydrotherapy pool.

People received one to one time from staff according to their needs, people received support to go on outings or regular walks throughout the day. During the inspection staff involved people in activities such as playing musical instruments and playing games. The statement of purpose informed people at Martha Trust had 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.

Relatives told us they knew how to complain and raise concerns with staff. There had been eight complaints in the last year and the governance meeting held in September 2017 stated all the complaints had been closed. Complaints were discussed each month and the complaints log was reviewed to look for any patterns and learning opportunity.

We reviewed three complaints that had been received by the service. These complaints were included on the complaints log and had been investigated and resolved although records were not fully completed. For example, a complaint had been dealt with over the phone but there was no information about when the phone call was made, what was discussed and the outcome. There had been a delay in sending an acknowledgement letter to one person.

Requires Improvement

Is the service well-led?

Our findings

There were mixed views from relatives, staff and healthcare professionals about the leadership and management of the service.

There was no registered manager in post, the previous registered manager left in March 2017. A new manager had been appointed and had started at the service in August 2017, they had not applied to be the registered manager at the time of the inspection. The manager was supported by two deputy managers, they were based in the two houses and responsible for the running of the houses on a day to day basis. Both the deputy managers were newly appointed and had both worked at the service previously.

There were mixed comments from the staff about the support they received from the management team. Staff told us they had not received the support and supervision they needed but were hopeful that the new managers would improve the situation. Some relatives told us that they were confident in the management team, others did not have confidence that the service was well led and that there was not an open culture.

Before and during the inspection, concerns were raised about communication within the service. There were a number of part time staff. Both staff and relatives told us that at times information had not been successfully passed on between staff. For example, one member of staff told us that they had not been aware that a new manager had been appointed. The manager told us they were aware of this and a clip board had been introduced for staff to read, to inform them of news and any changes. Following the inspection, the provider told us that staff received emails and text messages as well as having opportunity to attend monthly staff meetings to keep them informed of any important changes.

The deputy managers were based in the houses and were visible and available to staff and relatives. During the inspection staff and relatives were able to speak to the deputy managers and discuss any issues they may have. Some part time staff told us that they had not met the new manager and did not know until recently that a new manager had been appointed.

There were processes in place to monitor the quality of the service, however, these had not been completed consistently. We were told that the audits completed were usually checked by a director every six months and that this had not been completed recently due to change in management. The last available audit had been completed in May 2016. The provider had not put an action plan in place to make sure checks were completed during the change in management.

There were audits completed to check the quality of medicines, care planning, infection control and health and safety. These had not been effective in identifying the shortfalls found at this inspection. The care plan audit did not look at the detail in the care plans only that documents were in place and completed, medicines audit looked at the documentation completed. Action plans were not consistently written. The action plans were not detailed and did not contain information of who was responsible for any action and when it had been completed. Checks to the environment had not been audited to make sure people were safe.

Staff completed regular checks on the environment. Tap water temperatures were recorded on a monthly basis and there was a guidance sheet that stated, "Safe temperature should be between 37 and 43 degrees" this was to reduce the risk of scalding. Water temperatures in two bedrooms in Martha House and in one bedroom in Frances House were recorded above 44 degrees, there was no information recorded about any action taken.

Staff supervisions were not up to date to support staff to fulfil their role and identify and training they may need.

Records were not accurate and up to date. Care plans had not been consistently reviewed and did not always reflect the care being provided. Medicines records were not accurate.

The systems in place to check the quality of the care being provided were not effective. Records were not accurate and up to date. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This meant we could check that appropriate action had been taken. The manager was aware that they needed to inform CQC of important events, notifications were sent as soon as the manager was aware of the event.

Accidents and incidents had been recorded; a summary had been produced by an outside contractor. The report gave details of when most incidents occurred, to whom and by whom. Incidents had been investigated and discussed at weekly care meetings to determine if any further action was needed.

The provider sought the views of relatives by holding regular family forums where relatives had the opportunity to voice their opinions of the service. Some relatives told us that they often did not feel listened to and that their opinions had not been used to improve the service. Other relatives told us that the provider listened to parents and that there were three parent representatives involved in the service. Relatives had been informed of incidents and accidents within the service including medicine errors.

Surveys had been completed by staff and analysed. There had been a reduction in the staff response to the statement, I feel able to communicate with my supervisor/manager', only 60% of the staff responding agreed, ver 92% of staff said they felt they received the training they needed and 84% said they felt Martha House was a good place to work. The manager said they had an action plan that would be put in place. Surveys had been sent out to families and stakeholders, the results of the surveys were being analysed at the time of the inspection.

Staff demonstrated a good knowledge of the people and of the service. Staff understood their roles and responsibilities and who their line manager was. The provider had policies and procedures in place for staff to refer to.

Providers are required, by law, to display their CQC rating to inform the public on how they are performing. The latest CQC rating was displayed in the service and these details were also on the provider's website.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 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 The provider had failed to assess all risks and to have sufficient guidance for staff to follow to show how risks were mitigated when managing health conditions and health and safety. The provider had not ensured that guidance was followed to keep people safe. The provider had failed to protect people from the unsafe management and administration of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to check the quality of the care being provided were not effective. Records were not accurate and up to date. The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user.