Martha Trust

Martha House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service

Martha House is a residential care home, providing nursing care, for adults with learning disabilities, autistic spectrum disorder and physical disability. Most people living at the service had profound conditions, complex care needs and were unable to communicate verbally.

There are two houses on site, Martha House and Frances House, both houses were included in our inspection. The site, including both of the houses are registered with CQC under one location name, Martha House.

At the time of our inspection, there were 14 people living in Martha house and eight people living in Frances house. There was a vacant room in Martha House in which people stayed for respite care. Both houses were purpose built, they provided accommodation for people on the ground floor, they were spacious, well equipped and welcoming. The site included a specialty activity suite with a hydrotherapy pool, a quieter area equipped with touchscreen televisions and specialist eye gaze equipment. Eye gaze is a system which enables some people to communicate by tracking their eye movement. There was also a communal area used for some events and social activities.

The service had not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. Martha House was designed, built and registered before the guidance was published. The service was a large home, bigger than most domestic style properties. It was registered for the support of up to 23 people and 22 people were using the service. This is larger than current best practice guidance.

However, as to the size of the service having a negative impact on people, this was mitigated by the building design fitting into the residential area and the other domestic homes of a similar size. There were deliberately no identifying signs, intercom, cameras, visible industrial bins or anything else outside to indicate it was a care home. Staff were also discouraged from wearing anything that suggested they were care staff when coming and going with people.

While the design of the service did not meet current guidance, the service had however applied the principles and values of Registering the Right Support and other best practice guidance. This ensured that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service receive planned and co-ordinated person-centred support that is appropriate and inclusive for them. People's participation within the local community was encouraged and enabled.

People's experience of using this service and what we found

People were supported to stay safe, relatives told us they did not have any concerns about the support people received. They were, without exception, very complimentary about the service, its staff and management as well as the support people received. Relatives we spoke with told us they found the staff were, "Exceptionally caring."

Peoples needs were assessed before they moved to the service and further assessments were completed to ensure changing needs were met. Risks to people's health, safety and welfare were assessed, identified and regularly reviewed. Accidents and incidents were recorded, analysed and used to inform learning to reduce the risk of reoccurrence.

There were enough staff to meet people's needs. Staff had a good knowledge of people's support and communication needs. Medicines were managed safely, all staff administering medicines were trained and competency checked to ensure mistakes were minimised. Staff understood how to recognise abuse and the processes to follow should they have any concerns.

People's capacity to make specific decisions was assessed and, where needed, best interest decisions were made with the involvement of other relevant parties. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The service applied the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. This was included in people's care plans and reflected in the service's policies.

We observed people being encouraged and supported to make their own choices and decisions. Some people choose their own food and drink and staff knew how to support people with specific eating and drinking requirements. Staff were trained and knowledgeable about their roles. People were supported to remain well and healthy and had access to external health care professionals.

People's privacy and dignity was respected, people were encouraged to be as independent as possible. People's diversities were considered and respected. Staff spoke to people in a kind and considerate way, people appeared relaxed and confident in their home.

Care plans reflected people's needs and choices, guidance was clear and followed by staff so people received support in a consistent way. Relatives were involved in people's care and their input into the running of the service was encouraged. People took part in a wide range of activities; staff were sensitive to the fragility of some people's conditions and facilitated outings for family members to spend quality time with people.

People's communication needs were assessed, staff knew how to communicate with people in meaningful ways and the service was equipped with specialized equipment to facilitate this. A complaints procedure described how people could make a complaint or raise a concern, an easy read, eyegaze and screen touch version was available. Some complaints had been received since the last inspection. These were logged and responded to in line with the provider's policy; apologies were made when needed and all complaints were reviewed to inform learning.

There was an open and inclusive culture in the service. The registered manager and provider encouraged people, relatives and staff to feedback on any areas for change, so the service could improve. Staff felt

valued and well supported, performance evaluation was robust. Auditing had identified any areas of concern and action was taken in response to this.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 13 February 2019) and there were three breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-Led findings below.

Martha House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors on the first day and one inspector on the second day.

Service and service type
Martha House is a 'care home'. People in care homes receive accommodation and nursing care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The first day of the inspection was unannounced, the second day was announced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed the information we held about the service including previous inspection reports. We also looked at notifications about important events that had taken place in the service, which the provider is required to tell us by law. We contacted health and social care professionals to obtain feedback about their

experience of the service. These professionals included local authority commissioners, the local authority safeguarding team. We used all of this information to plan our inspection.

During the inspection
Some people were unable to verbally tell us about their experiences, so we made observations of care to help us understand the experience of people who could not talk with us. We spoke with six staff, the deputy and registered manager as well as various administration staff and heads of departments. We also spoke with four visitors during the inspection.

We reviewed a range of records. This included three people's care records and aspects of other people's care records as well as medicine records. We looked at a variety of records relating to the management of the service, including audits and checks, maintenance records, accident and incident records, complaints and policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found; all information requested was received. We also received feedback from two relatives of people that used the service.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now improved to Good. This meant people were safe and protected from avoidable harm.

Assessing risk, safety monitoring and management
At our last inspection the provider was in breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had failed to do all that was reasonably practicable to manage risks to people's health and safety, in addition, medicines were not always managed safely.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 12.

● At the last inspection, fluid intake had not been effectively monitored. Inconsistencies in recording fluid introduced a risk staff would not identify when a person was not drinking enough, possibly leading to urine infections and dehydration. At this inspection, records of hydration were clear. Where needed, people had individual hydration targets and staff recorded fluid amounts clearly. The electronic care record system required staff to enter details of fluid consumed. Non recording or potential shortfalls raised real-time alerts, allowing early interventions if needed.
● Risks to people's health, safety and welfare were assessed, identified and managed. Measures were in place, which staff followed, to reduce risks to people. For example, when people were at risk of skin breakdown, staff made sure they had pressure relieving equipment, such as special mattresses. Where needed, people had profiled sleep support systems or orthopaedic chairs, to help to maintain their posture.
● Risk assessments centred on each person, they were reflective of individual needs, reviewed regularly and kept up to date. For example, some people experienced epileptic seizures. There was detailed guidance in place which staff followed, this included how people should be monitored while awake or asleep and the support, medication and intervention needed in the event of a seizure.
● There was a detailed handover system between shifts to make sure information about risks to people was shared consistently. This had been enhanced following an incident stemming from a failure in communication. Handover information was uploaded to the care planning system and available for all staff to review. Any specific support tasks were allocated to named staff. Regular checks were completed to make sure the environment was safe. For example, fire detection and prevention systems and specialist support equipment was regularly serviced and well-maintained.

Using medicines safely
● At the last inspection medicines were not checked in to the service quickly and were not always available when people needed them. At this inspection improvement had been made. The provider had moved the medication room in Frances House to a larger room, this allowed more space to implement revised checking in processes. The home administrator and other staff checked in all medicines and medicine

administration records (MAR) to ensure they were correct. The additional staff resource had speeded up this process and medicines were available when needed.

● People received their medicines when they needed them. Records of medicines were complete; processes to order and dispose of any unwanted medicines were well managed. Medicines with special storage requirements were stored and recorded appropriately. Staff followed best practice guidance when recording administration of prescribed creams and adhesive skin patches used to relieve pain. Body maps were used to make sure staff knew where to apply creams and where to place pain patches.

● People's medicines were reviewed annually, or when their needs changed to ensure they were still required and appropriate. Where some people were unable to take medicines orally, detailed instructions advised specially trained staff how to administer them through a PEG (Percutaneous endoscopic gastrostomy) and how to care for the site. A PEG is a tube which is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.

● When medicine instructions were hand written, the instruction had been signed by two staff, to confirm it was correct. Staff had received training to administer medicines and their competency was checked regularly. Medicines were regularly audited to identify any errors.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● Visitors told us they felt reassured by the level of care delivered and did not have any concerns about the safety or treatment of their family members. One visitor told us, "I have absolute faith in the staff and the care and support provided." We observed people were relaxed in the company of each other and staff; people were readily receptive to interaction with staff and were at ease.

● People were protected from the risks of abuse, discrimination and avoidable harm by staff who were trained on how to keep people safe. Staff knew how to report any concerns and felt confident the registered manager would take the right action. Staff were aware they could take their concerns to external agencies, such as the local authority or the Care Quality Commission (CQC).

● There were effective safeguarding systems, policies and procedures in place which were followed by staff. The registered manager understood when incidents needed to be reported to the local authority and CQC.

● Accidents and incidents were recorded and analysed to identify any patterns or trends. Lessons were learnt from specific incidents and measures implemented to prevent repeated incidents.

● For example, there had been an incident when a person was left unaccompanied in the toilet for an extended time period. This occurred because of a miscommunication at staff handover. Working practice was reviewed, staff now checked each person at the beginning of each shift and remained physically present outside of toilets until people no longer need their support. The electronic care logging system was enhanced to provide an alert if staff did not record a care activity as completed.

● Any incidents or near misses were discussed during staff meetings and at staff supervision meetings as appropriate. This helped staff reflect on their practice and discuss individually and as a team what could be done to improve the care and support people received.

Staffing and recruitment

● People were supported by staff who had been recruited safely. Recruitment systems were robust. Criminal record checks were always completed to make sure new staff were safe to work with people. References were provided to ensure staff were of good character. Nurses' registrations with the Nursing and Midwifery Council were checked.

● People were supported by a consistent staff team. There were enough staff in each house to provide people with the support they needed, when they needed it. Rotas showed the service was staffed above the minimum required, this included staff providing one to one care. People's relatives told us there were always staff available when they needed to speak with them. Throughout the inspection staff were not rushed and had time to spend with people.

● The registered manager monitored staff levels and adapted these according to people's changing needs. There were contingency plans to cover emergency shortfalls, such as sickness. Occasionally agency staff were used and was usually for care staff rather than nursing positions. However, the service had been working to reduce agency use. For example, temporary changes were made to overtime payments to encourage established staff to work additional shifts and reduce agency staff use.
● Although staff turnover was relatively low, the management team were looking at ways of increasing staff retention. This included providing good quality training, lines of progression, introducing seniors posts and giving some staff more responsibility. For example, some staff had been given the opportunity to specialise as Communication Champions, Rett Champions, Safeguarding Champions and Dignity Champions,

Preventing and controlling infection
● People lived in a service which was clean and free from unpleasant odours. Staff completed regular training about infection control and understood their responsibilities to maintain high standards of cleanliness and hygiene in the service.
● Staff had access to and followed clear procedures on infection control. The registered manager made sure people, staff and visitors were informed of processes in place to keep up to date with current national guidance. For example, posters had been put up to provide guidance on measures, such as hand washing and the use of anti-bacterial gel.
● Staff wore gloves and aprons when supporting people with personal care to reduce risks of infection.
● Laundry processes established working practice to prevent the risk of cross-contamination between clean and dirty laundry. People had their own lifting slings, they were not shared between people which reduced the risk of transference of infection. Lifting slings were regularly laundered.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Assessments were completed before people moved to the service and transitions often took place over an extended time. Care delivery followed recommendations made by healthcare professionals. For example, assessments were designed to support people's posture and, in some cases, reduce the impact of adverse breathing complications.
- Part of the assessment process included looking at peoples protected characteristics. The Equality Act 2010 protects certain characteristics including age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion, sex and sexual orientation.
- The service used nationally recognised guidance to assess people's health. These included assessments about skin integrity and MUST. (Malnutrition Universal Screening Tool is used to assess if people are malnourished, at risk of malnutrition or obesity). A DisDAT tool helped staff recognise when people were in pain. Nursing staff used a standardised system to record and assess baseline observations of people to promote effective clinical care. It included actions staff should take if their checks were outside of the baseline and a person's health deteriorated.
- Staff knew people's care needs exceptionally well and were able to quickly recognise changes in people's condition. People's physical, mental health and social care needs were assessed, people were continually assessed for changing needs.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- Care records documented that people were supported by a range of healthcare professionals, such as GPs, physiotherapists, speech and language therapist (SALT) and specialists for specific health conditions. For example, the Home Enteral Nutrition (HEN) team provided staff with specialist information, support and training to help manage PEG rigs, PEG feeding and safe eating and drinking. This helped to ensure people received effective, joined-up care.
- One relative told us, "Over the last 18 months staff have gone above and beyond for our son. He has a hospital pathway and was admitted following a bout of pneumonia. Following this, physio set up a regime of postural drainage three times a day for an hour. Martha House staff are doing this and this is now the second winter our son has kept out of hospital. This makes a tremendous difference to him and us."
- People's oral hygiene needs were assessed to make sure their teeth were looked after. People had regular dental checks. Staff completed training, based around the Care Quality Commission 'Smiling Matters' report to make sure they had up to date knowledge and were following best practice guidance.

Supporting people to eat and drink enough to maintain a balanced diet

● People were given a choice of meals. Where possible, people chose what they ate and where they ate their meals. Some people's nutrition was provided via PEG feeds, but where safely allowable, staff supported some PEG fed people to have oral food tasters. This enabled people to enjoy the flavour of food and experience the texture of food in their mouths.
● Where people were at risk of aspirating (breathing in) food, the chef met with the SaLT team to ensure the food they prepared met specific requirements. Some people needed thickened fluids to help them to swallow safely. Staff were knowledgeable about this and confidently explained the consistency of drinks relevant people needed.
● People were asked daily what they would like to eat. Staff used appropriate means to support people to make choices. Staff used their knowledge of people's likes and dislikes if people were not able to make a choice about their food.
● People's cultural, ethical and religious needs were considered when meals were planned. For example, kitchen staff would accommodate vegetarian or vegan meals if required. We observed the lunch time meal, it was a relaxed and social occasion; people's meals were hot and looked appetising. Where needed, people received support to eat their meals at a pace that suited them.

Staff support: induction, training, skills and experience
● Staff told us they were supported by the registered manager and management team. They received regular supervision meetings and felt able to feedback about any concerns they may have. For example, training delivery was evolving based on staff feedback and some training would now be delivered by e-learning. This followed consultation with staff which found face to face training for some subjects had become repetitive.
● There was a training plan in place and staff were trained to meet people's complex needs. Staff told us they felt competent and would ask for support and further training if they felt it was required. Relatives we spoke with regarded staff as knowledgeable and appropriately trained. Competency assessments were completed for nurses and care staff to check they had the required skills.
● New staff received an induction. This included basic training topics and working with more experienced staff to learn about people, their choices and preferences. Before new staff worked alone, their competencies were checked and they were given feedback on their progress. New staff also completed the Care Certificate. This is an identified set of minimum standards that sets out the knowledge and skills expected of specific roles in health and social care.
● Staff had been supported with their personal development and had the opportunity to undertake additional qualifications. For example, 60 staff had level two vocational qualifications and 46 had completed the care certificate. Nurses revalidations were supported to enable renewal of their registration with the NMC. Monthly checks ensured nurses had a valid PIN and did not have any practice restrictions.

Adapting service, design, decoration to meet people's needs
● The service provided accommodation for people on one level. Corridors and communal areas were spacious, enabling people who used wheelchairs to navigate easily. Both houses were light and welcoming. Bathrooms were well proportioned and well equipped, there were specialist baths and showers and enough room for staff to support people safely.
● Rooms were personalised and tailored to meet people's needs. Adaptations had been included to meet people's needs. For example, bedrooms and bathrooms were equipped with overhead hoist tracking to support people to move between their bed and chair and bathing facilities.
● The activity centre was equipped with a hydrotherapy pool and also contained interactive entertainment equipment and other equipment to develop and support people's communication. This met people's needs and promoted independence; facilities such as these were not otherwise available within the community.
● There was a large space for activities and social gatherings. On the first day of our inspection, staff had

arranged a party and buffet in the activity centre to celebrate a person's birthday. People had access to gardens and a large decked area. Visits from family and friends were encouraged and people could see their visitors in private if they wanted to.

Ensuring consent to care and treatment in line with law and guidance
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 mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- People's capacity to make specific decisions was assessed and reviewed. When people were unable to decide for themselves, such as a decision to live at the service, the registered manager met with people's representatives and health care professionals to make a decision in the person's best interest. The decisions made at these meetings were clearly recorded.
- People were supported in the least restrictive way by staff who understood the importance of giving people choices. For example, some people experienced epileptic seizures and audio devices, or mattress sensors were used to alert staff a person may be experiencing a seizure. These reduced the need for staff to continually look in on people, but ensured people received support when needed.
- People were empowered to have as much control and choice as possible. Throughout the inspection people were offered choices, such as where they would like to spend their time, what they wanted to do and what they would like to eat or drink.
- The registered manager applied for DoLS, and notified the Care Quality Commission of authorised DoLS, in line with guidance.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has remained Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- The service focused on building and maintaining open and honest relationships with people and their families, friends and other carers. Parent and representative forums were well established to facilitate this. There was a strong, visible person-centred culture. The service worked in a way that enabled them to listen to people's preferences as well as considering the thoughts of families or advocates. Person centred care was provided in a way which reacted as and when individual choices or needs changed.
- For example, one person who was non-verbal did not want to attend their activity session. Staff supported them to use a mobile eye gaze system. This enabled the person to tell staff they had back pain and wanted to be moved from their chair; they also asked for pain relief. Staff supported the person as requested, who then thanked them through the eye gaze. The person is now encouraged to communicate using this system to let staff know how they are feeling and what they can do to help.
- The person now asks staff, using eye gaze, to play songs or request specific films and programmes to be used on the magic carpet. The person found this a completely immersive experience, all of which they had chosen. (The magic carpet projects interactive games and images onto the floor that users can play with and control by moving on or over the projected image).
- All staff were motivated and provided care and support that was compassionate and kind in the way they cared for people. For example, staff provided Christmas presents for people and shared alcohol-free beer and festive food with some people over the festive period. A family commented, "A massive thank you to [named member of staff] and all the staff for his care and for the beautiful Christmas presents. We appreciate it." On another occasion, when staff became aware a person had a passion for sports cars, they organised a surprise for them; a Ferrari visited the site. The person was delighted.
- Staff were particularly sensitive at difficult times. The registered manager told us they felt honoured to arrange a holiday for a terminally ill person. Staff supported them to spend time away from Martha House with their family and make valuable memories. Sadly, the person passed away a few weeks later. In an email, the family warmly reflected how staff had stood by them at difficult hospital meetings, and all the times the person had a carer 'friend' with them when they stayed in hospital. They said, 'Our words can't really express how grateful we are to the wonderful carers at Martha House, not just during the last difficult year but throughout the previous 20 years when it was [person's Name] happy home'.

Supporting people to express their views and be involved in making decisions about their care

- People were supported to express their views so that staff and managers understood them. Staff used a variety of tools to communicate with people according to their needs, including using technology. The service used eye gaze systems and a touch sensitive television screen which enabled non-verbal people to

clearly communicate. This enabled them to tell staff how they feel, what they want to do and any changes to their support preferences.

● Staff made sure people got the support they needed. For example, one person did not want to attend hydrotherapy sessions, staff discussed this with them and found if they referred to the sessions as swimming, the person was happy to take part. This was because of negative connotations the person associated with therapy. The person now enjoys regular swimming sessions.

● Another person identified they would like help with numeracy. Since moving to Martha House, they can now count. They also recently learned to use a pacer walking frame and move independently around the home. This provided a new-found freedom, to their visible delight. Their family member commented, " All the staff are so friendly and helpful, nothing is too much trouble. When I visit, it's an absolute pleasure to see how settled and happy he is."

● Staff welcomed the involvement of advocates and information about advocacy support was available. Staff encouraged advocates to be involved in people's daily life as much as possible. For example, two people had no family members; staff ensured they both had named advocates. Advocates were invited to annual care reviews, best interest meetings and events such as people's birthday parties.

Respecting and promoting people's privacy, dignity and independence

●Respecting dignity and privacy was at the heart of the service's culture and values. People and staff felt respected, listened to and influential. Staff anticipated people's needs, recognised distress and discomfort at the earliest stage and offered sensitive and respectful support and care. A relative commented, "Without the incredible work, care and support of your amazing staff [person's name] would not have survived. I am eternally grateful once again to the professionalism and determination of the whole team."

● Staff had a good understanding of people's needs transitioning from other services. They made sure people and their families were closely involved in transfer planning. For example, one person moved to the service from a children's trust. A nurse, key worker and a therapy support worker from Martha House visited the person in their old setting. Meeting the person, their family and existing care team, enabled staff to see and learn about daily care needs, communication and likes and dislikes. This helped to ensure their preferences and needs were understood.

● The registered manager commented, "When we make a transition plan it's centred around the feelings and needs of the person. Transition can take anywhere from a few days to weeks, completely dependent on how the person feels and whether they are comfortable and settled."

● Supporting people's equality, diversity and human rights was embedded in the service. For example, at Christmas, people and their families were invited to join in religious celebrations and carols. Relatives were made to feel welcome and able to visit without restriction. The service honoured and celebrated different beliefs and had created a culture where people, families and staff are proud of the service.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care was planned with them, their relatives and advocates to meet individual needs and preferences. This provided an opportunity to gain information about people, particularly if a person had difficulty remembering or expressing their views; care delivery met people's needs and wishes.
- For example, one person often refused fluids and ate very intermittently. This led to increased epileptic seizures and severely impacted their quality of life. Staff supported the person and their family to understand the potential benefits of introducing a PEG and worked closely with a multi-disciplinary team to have a PEG fitted. The person's quality of life was transformed, they now met their daily fluid target and received medicine regularly to control their epilepsy.
- Each person was allocated a key worker who was responsible for reviewing areas of the person's care such as daily living skills. People met with staff and were able to plan and talk about upcoming activities. Activity planners reminded some people what they had talked about and when activities would happen. Staff were knowledgeable about people's preferences and told us about things that were important to them.
- People were supported to plan and achieve goals. Goal setting for people with learning disabilities is recognised as essential to help them feel positive and in control of their lives. Goals for some people ranged from introductions to use eye gaze technology, to specific tasks, such as, using walking equipment and planning for social activities, outings and holidays.

Meeting people's communication needs; improving care quality in response to complaints or concerns
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were assessed before they began living at the service and were regularly reviewed. Staff placed great emphasis on communication and used tools and technology to enable people to express their views.
- Some people were unable to verbally say if they were unhappy or anxious. Staff recognised this and knew how people should be supported and how they communicated in their own specific way. During the inspection, staff identified what some people wanted to communicate by their vocalisations, facial expressions and body language. Staff responded in an appropriate way.
- People received important information in a format that suited them best. For example, clear signage in written and pictorial forms indicated where toilets, bathrooms, dining rooms and lounges were. Information was displayed in easy to read formats and some was available in electronic touch screen formats, for example, information about safeguarding and how to make a complaint.

● Complaints were received, logged, investigated and responded to in line with displayed information. Since the last inspection, 12 complaints received had been investigated and responses given. Staff have apologised when things had gone wrong. There was no evidence that situations continued or recurred after a complaint had been resolved.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were encouraged to be as active as possible. An activity co-ordinator provided a wide variety of individual and group activities to keep people busy. Specially adapted transport was available to facilitate outings.

● Regular outings included trips to the 'music man' which involved people with learning disabilities interacting with the music. Other activities have included disco nights, 'wet wheel' trips out of Dover on a speed boat, carriage riding, visits to the theatre and cinema as well as shopping trips to enable people to be involved in the choosing of their own clothes and toiletries.

● Some people had been on specific activities. For example, one person visited a wildlife park tiger experience, this enabled them to see their favourite animal. Activities were reviewed and updated often. Religious and cultural preferences were documented. Where people identified with a specific religion and were supported to go to church or place of worship.

● People enjoyed on-site activities too. There was a large space for social gatherings, arts and craft and individual activities.

End of life care and support

● The service was not supporting anyone at the end of their life.

● Staff had spoken with people and their relatives about end of life plans and, where people had agreed, written plans were in place. Staff gave an example of one person's wishes which would enable them to remain at Martha House, rather than having to go to hospital. Staff were discussing anticipatory care plan with them and their family.

● Staff had received training about end of life care and were able to give examples of other healthcare professionals they may need to consult with, such as specialist nurses, hospice services and GPs for anticipatory medicines. These are medicines people may need towards the end of their lives, for example to help to control pain. They are prescribed and held in stock at the home before they are needed so there is no delay in getting them.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now improved to Good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider was in breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured that the systems in place to check the quality of the care being provided were effective. In addition, the provider was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because the provider had failed to ensure notifications were submitted to CQC when there was a notifiable event.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulations 17 or 18.

● Leadership was clear, strong and visible. The registered manager and support team set high standards. Staff told us the management team were approachable and committed to providing high quality care. Key staff were given other delegated responsibilities. Trustees representing the service provider were based on site regularly and provided support to the registered manager. Staff were clear about their roles and communication between the staff team was effective.
● At the last inspection audits were not consistently robust. At this inspection, effective governance was embedded into the daily running of the service. A wide range of robust checks and audits monitored risks, the quality of service and staff performance. When shortfalls were identified, action was taken to address them.
● It is a legal requirement that a service's latest Care Quality Commission inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. The registered persons had conspicuously displayed their rating both in the service and on their website. Statutory notifications were submitted to CQC when needed.
● There was a business continuity plan that described what steps would be taken to keep people safe in exceptional circumstances such as a fire or flood. Stand by generators were located on site to provide electricity in the event of a power cut. Plans were being developed in line with Government guidance about minimising the risks of exposure to Coronavirus.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good

outcomes for people; Continuous learning and improving care

● People and their relatives spoke positively about the management team and staff. There was an open and inclusive culture where people were consistently involved and valued. Relatives told us the registered manager's door was, "Always open and the manager was welcoming."

● People were in control of their care and were provided with support to do this. People were surrounded by their family, friends and people who were important to them; there were no restrictions on visiting. The registered manager and staff spoke passionately about the importance of collaborative working with people, relatives and health care professionals to achieve the best outcomes for people.

● The service had introduced a family forum twice a year. Everyone was invited to meet with the registered manager, CEO and other managers if needed. A parent representative group had been established with three members of people's families who met with the management team quarterly. They were able to feed into the agenda for the family forum. People using the service were supported to attend and feed into meetings if they wanted to.

● The registered manager spoke about the importance of having a consistent staff team who worked well together. Analysis had been completed of a recent staff survey, this showed staff were happy and Martha Trust was a good employer. The management team were looking at staff retention. Exit interviews took place for all staff to look for patterns and trends. Some left for more money or carer progression; some staff also came back. Analysis of this data had led to number of incentives being introduced.

● The registered manager and staff were committed to continuous learning and improving care. The registered manager was a member of the registered managers network; the CEO attended a learning disabilities (LD) focused network. Staff also attended a Profound Multiple LD conference. The registered manager and key staff held meetings to reflect on clinical governance and the Clinical Lead had been invited to join an LD steering group in Sussex. Staff received updates from Skills for Care and used their website.

● Management were alert to potential difficulties within the service and acted to address them. For example, a concern was raised about acceptable boundaries between staff and the people they supported. The senior management team reflected on this and the language used, such as, Martha is a 'family'. It is now referred to as a 'community' to make sure staff are aware of the boundaries. This has been communicated to all staff and included in safeguarding training and posters about the code of conduct displayed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The registered manager welcomed feedback. When minor concerns had been raised in conversation with people or their relatives, these were recorded, and the registered manager took action in response.

● Regular residents' and relatives' meetings were held to check on people's satisfaction of the service they received. Quality surveys were conducted annually, and the results analysed to see if there were any areas for improvement and to celebrate areas of success.

● Regular staff meetings were an opportunity to share experiences and learn from each other. Handovers were completed between shifts to make sure all staff had up to date knowledge about the people they supported.

● Staff worked closely with health care professionals to make sure there was consistent, joined-up care. There were strong links with the local community and volunteers.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

● The registered manager promoted a culture of openness and transparency. Robust quality assurance systems, completed by the registered manager and key staff, were used to help focus on continuous improvements across the service. These gave the registered manager good oversight of the service.

● The registered manager understood their responsibility under duty of candour which requires them to be

open and honest with people when something goes wrong.