Martha Trust

Martha House

Inspection report

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Date of inspection visit:
03 December 2018
04 December 2018

Date of publication:
13 February 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 3 and 4 December 2018. The first day of the inspection was unannounced, we told the provider we would be returning on the second day.

Martha House is a residential care home for up to 23 adults with a learning disability. There are two houses on the site Martha House and Frances House, both houses were included in this inspection and are registered with CQC under the name of Martha House. There were 13 people living in Martha house and 8 people in Frances house at the time of inspection. The houses were both single level. There is an activity centre on the site which included a hydrotherapy pool. Martha House is a 'care home'. People in care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care service had been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

At the last inspection on 5 and 6 October 2017 the service was rated overall as requires improvement. Following this we asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe, responsive, effective and well-led to at least good. At this inspection we found that the rating remained requires improvement. This is the second consecutive time the service has been rated Requires Improvement.

There was no registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission 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. At the time of the inspection the registered manager had left the service but had not yet de-registered. The service told us that the director of operations intended to register as the manager. However, the application had not been received at the time of the inspection.

At the previous inspection we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to assess all risks and did not have sufficient guidance for staff to follow to show how risks were mitigated when managing health conditions and health and safety. Also, the provider had failed to protect people from the unsafe management and administration of medicines. At this inspection we found that risks to people had been assessed. However, where mitigations were in place these were not always monitored. Care plans were updated but the service was in the process of transitioning from paper to electronic care plans and the paper records were not always up to date but were still being used by staff. There continued to be concerns relating to the safe management of medicines. Medicines were not checked in to the service quickly and were not always available when people

needed them. Further improvements were needed to be made and the service remained in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The systems in place to check the quality of the care being provided were not effective. Records were not accurate and up to date. At this inspection we found that whilst the electronic care plans were up to date the paper care plans were not and the service was still using both to provide care to people. There was a system of auditing in place, but these checks had not identified the issues we found at this inspection. For example, paper care plans were not being regularly updated and staff were not recording fluid intake in a consistent manner. Further improvements were needed to be made and the service remained in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we also found a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The provider had failed to make sure that notifications were submitted to CQC when there was a notifiable event.

The service was in the process of improving the prevention and control of infection. An audit had been completed and the actions identified were being undertaken but had not yet been completed.
We made a recommendation about this. People were protected from risks in the environment such as the risks from fire. Staff continued to carry out regular health and safety checks of the environment to make sure it was safe. The premises were suitable for people's needs.
When things went wrong lessons were learnt and improvements were made. Information was analysed for trends and where these were identified the service had taken action.

People were protected from abuse. Staff had undertaken safeguarding training and knew how to identify and report concerns. Where concerns were raised these were investigated and action was taken. However, safeguarding concerns were not always reported to the local authority and CQC when they needed to be.

There were enough staff to keep people safe. The service was using agency staff as there were vacancies at the service. The service was actively recruiting and interviewing new staff at the time of the inspection. Staff were recruited safely, and the necessary pre-employment checks were carried out such as checking references.

Before people moved in to the service or came for a period of respite an assessment of their needs had been completed. The information from the assessment was used to develop a care plan for the person and assess staffing levels. People's support plans were personalised and were based on their needs and choices.

Staff had the training, skills and knowledge they needed to support people. When new staff joined the service, they completed an induction which included undertaking mandatory training and shadowing more experienced members of staff. Staff received appropriate levels of supervision, their competency was checked and there were annual appraisals. Staff told us that they felt well supported.

People were supported with eating and drinking. When people did not like the food offered they were provided with an alternative. Where people were at risk of choking they had been referred to the speech and language team (SaLT) for an assessment of their swallow so that the service had information on how people could best be supported to eat safely.

Staff worked together to support each other to deliver effective care. Where people needed access to health

care this was provided. There was information for people to take to hospital with them where this was needed.

Staff worked within the principles of the Mental Capacity Act 2005 (MCA). Best interest's meetings were held where people needed support to make decisions. People were offered day to day choices where they were able to express a preference.

Staff treated people with kindness and compassion. People were treated with dignity and their privacy was respected. Records relating to people and their needs were kept securely. The service was introducing technology to improve communication and develop ways to support people to express their views. People had access to activities and we saw that people participated in a range of activities which they enjoyed. Relatives were free to visit. There were plans in place for the end of people's lives and these were being developed further.

When the service had received complaints, we saw that these had been analysed and acted upon and changes were made to the service.

The service had a clear vision for the future and had development plans in place to enable them to work towards this. Relatives, staff and professionals were invited to provide feedback annually via questionnaires. Where comments had been made or feedback was not always positive an action plan had been developed to make improvements. The service worked in partnership with other organisations to develop best practice and share information with others. The provider had clearly displayed their rating at the service and on their website.

During this inspection we found two continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. We also found one breach of the Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 consistently safe

Medicines were not always well managed.

Risks to people were assessed and there were mitigations in place but these were not always recorded appropriately or monitored.

People were protected from the risk of abuse.

The service was clean and improvements were being made to infection control.

There were enough appropriately recruited staff to keep people safe.

People were protected from the risks from the environment.

Where incidents had occurred these were investigated and acted upon.

Is the service effective?

Good

The service was effective.

Peoples needs had been appropriately assessed and reviews of people's needs and support were carried out as necessary.

Staff had the skills, knowledge and training they needed to support people. Staff were appropriately supervised.

People were provided with the appropriate support to eat and drink safely.

People had access to healthcare professionals when they needed them.

The building was appropriate to meet people's needs.

The provider followed the principles of the Mental Capacity Act (2005).

Is the service caring?

Good

The service was caring.

Staff were kind and caring and engaged with people in a meaningful way.

People were supported to express their views and were involved in decisions about their own care as far as possible.

Staff provided people with support to maintain their dignity and privacy.

Is the service responsive?

Good

The service was responsive.

People's support plans were personalised and contained information on how people liked to be supported.

There was a complaints policy in place and people and their relatives knew how to complain if they chose to do so.

There were plans in place for the end of life which were continuing to be developed.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Audits had not always identified shortfalls in the service and action had not always been taken to address any concerns identified.

The management team were not always aware of their roles and responsibilities and notifiable incidents were not always reported to CQC.

Staff were happy in their role and felt well supported by the provider and that their views were listened to.

Relatives, staff and professionals were invited to feedback about the service. Communication in some areas had been a concern but the service was actively addressing this.

The service worked in partnership with other relevant organisations.

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 comprehensive inspection took place on 3 December 2018 and the 4 December 2018. The first day of the inspection was unannounced, we told the management team we would be returning on the second day of the inspection.

The inspection team consisted of one inspector one learning disability nurse specialist advisor and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the previous inspection report and notifications about important events that had taken place in the service which the provider is required to tell us by law. We used this information to help us plan our inspection.

We spoke to three people's relatives. People did not engage verbally about their experiences of the service, we observed the interaction between people and staff in the communal areas. We completed a short observational framework for Inspection (SOFI). SOFI is a way for us to observe people and staff interaction and understand the experience of people using the service.

We looked at ten people's support plans and the recruitment records of five staff employed at the service. We viewed a range of policies, medicines management, complaints and compliments, meetings minutes, health and safety assessments, accidents and incidents logs. We looked at what actions the provider had taken to improve the quality of the service.

We spoke with the provider, the director of operations and other members of the management team. We

spoke to four nurses, four support workers and the kitchen supervisor.

We sought feedback from relevant health and social care professionals and staff from the local authority on their experience of the service. We contacted Healthwatch, who are an independent organisation who work to make local services better by listening to people's views and sharing them with people who can influence change. We also spoke to one health and social care professional whilst visiting the site.

At the inspection we asked the management team to send us some further information about training and the risk assessments for one person. This information was received by us in a timely manner.

Requires Improvement

Is the service safe?

Our findings

Two relatives told us that they felt that the service was safe. One relative told us, "I really feel my [relative] is safe here. She has been here [a number of] years, so I am confident that she is safe." However, one relative told us that they needed to prompt staff to follow things up in order to ensure that the service was safe.

At the previous inspection on 05 and 06 October 2017 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to assess all risks and did not 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 made sure that guidance was followed to keep people safe. At this inspection we found that the provider had taken some steps to improve but there continued to be some concerns. There were fluid charts in place where people needed support to make sure they were hydrated. Prior to the inspection we had received some concerns that people's fluid intake was not well monitored. We looked at one person's fluid chart from the week commencing 19 November. The person was at risk of developing urine infections and had more than one infection in the last year. On three of the days where fluid was recorded the amount drunk was very low. One day it was as little as 265ml. We discussed this with nursing staff and the management team who were not able to explain the low level of fluid recorded at the time of the inspection. After the inspection the service was able to demonstrate that the person had drunk more but that staff had been recording fluid intake in different ways. This was not identified until we raised it during the inspection. This meant that fluid intake had not been effectively monitored and there was a risk that the staff would not identify when the person was not drinking enough and was at risk of further urine infections or dehydration. Immediately after the inspection the service wrote to us to evidence that they had highlighted to staff the inconsistencies in recording fluid and inform staff how to record fluid correctly.

At the time of the inspection the service was in the process of moving from paper care plans to electronic care plans. The management team told us that both care plans were to be kept up to date to make sure that staff had access to the information they needed to keep people safe. We found a number of areas where the electronic care plan had been updated and the paper care plan had not. Some staff told us that they were still learning to use the electronic care plan and still used the paper care plans. One member of staff said, "The electronic care plans at the moment are task focused the 'how to' is in the paper records." For example, one person stayed at the service for periods of respite. The person's needs had changed, and this had not been documented in the paper care plan. The electronic care plan detailed that if the person's catheter became blocked they were to be taken to A&E, but this information was not in the paper record. The staff we spoke to were aware that the person's needs had changed, and we saw that this was discussed at the handover meeting. However, there was a potential risk that staff would not know how to deal with emergencies as they arose.

Some improvements had been made since the last inspection. For example, at the last inspection we found that the risk assessments for people living with epilepsy varied in detail. Since the last inspection these had been reviewed and updated and there was now consistent guidance in place to support staff. One person had moved to the service very recently and their care plan and risk assessments had been completed and

were thorough. Where people were at risk of becoming unwell there was information for staff to enable them to identify this. For example, what staff needed to look for to identify that a person was at risk of a urine infection. Where people needed support to move around the service staff had completed face to face moving and handling training.

At the last inspection we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The provider had failed to protect people from the unsafe management and administration of medicines. At this inspection there continued to be concerns. There was a medicine room in each of the two buildings. The recent infection control audit undertaken by the service identified one of these rooms as 'crowded and small'. The complexity of people's needs had increased since the service registered. This meant that the medicines rooms were now no longer large enough to store everything well and made it a difficult space for staff to work in.

Medicines were checked in to the service by one nurse. When we looked at one medicine room we saw that medicines that had arrived in the morning had not been put away and were sat in boxes on the floor. These medicines were still in the boxes on the floor when we returned the next day. On the second day of the inspection we saw that one person had not received one of their medicines which was used to prevent constipation. Staff had marked the person's medicine administration record (MARs) to indicate that the medicine was not available. However, we saw that there were stocks of the persons medicine in the boxes on the floor. Staff were not able to use these medicines as they had not yet been checked in by the nurse responsible. Staff told us that the medicines would not be checked in and would remain in the boxes on the floor until the end of the week meaning that the person was at risk of not having their medicine for another 3 days. The system to check in medicines needed to be improved to make sure that people's medicines were stored safely and were available when needed. There were similar concerns about the disposal of medicines that were no longer needed. One person had died, and their high-risk medicines were still in the medicine room 4 weeks later. We raised our concerns with the management team at the time of the inspection.

There were also some areas of medicine administration that had been improved since the last inspection. At the last inspection we found that there were no guidelines for staff to follow about when to give 'as and when' (PRN) medicines, how often and what dose. These guidelines were now in place. For example, where people's bowel movements were monitored to make sure that they were not constipated there was information on when to use a PRN medicine and the dosage to administer. There were also protocols in place to provide staff with the information about how PRN medicines could affect people and how often they could be given. The medicines we checked were all in date. Medicine administration records were complete and accurate. Where people had medicines, there was information for staff on when these medicines should be used. There had also been a significant reduction in the number of medicine errors at the service since the last inspection.

The provider had failed to do all that was reasonably possible to mitigate risks to people's health and safety. Medicines were not always managed safely. This is a continued breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had identified that the prevention and control of infection was an area that needed further improvement. In order to meet this aim they had recently restructured one member of staff's role to enable them to take the lead in this area. This person would also oversee the staff who cleaned the service and the audit process. An infection control audit had been done in November 2018 and work was being undertaken to make improvements at the time of the inspection. The audit identified that staff would benefit from having access to spills kits and these had been ordered. Spills kits are used to deal with cleaning up body waste fluids such as vomit and contain the items staff need to deal with these safely. There were some areas

where further work was still needed. For example, in one bathroom there was a trolley that made it difficult for staff to get to the clinical waste bin and then to the sink. We spoke to one of the directors and suggested that this trolley should be moved to make it easier for staff to dispose of waste and then wash their hands. The medicine room would also be challenging to keep clean as there were boxes on the floor. People were protected from the risk of waterborne infection. The water system had been recently checked for Legionella bacteria and the water system was regularly flushed to make sure that the system remained bacteria free.

We recommend that the service continues to make the improvements outlined in the providers infection control audit.

Staff had received up to date safeguarding training. When we spoke to staff they were able to explain the signs of abuse and knew how to report this both within the organisation and who to report to externally if they felt that the concern had not been addressed. Staff told us that they were confident that any concerns would be acted upon. The provider was in the process of a project to enhance staffs understanding of safeguarding and improve safeguarding practice within the organisation. The provider told us that they aimed to become one of the leading organisations in safeguarding practice. This improvement work was still in progress, but some actions had been completed. For example, staff had completed further training and safeguarding champions and leads had attended extended safeguarding training. The provider has also produced a summary of the safeguarding policy for staff as a quick reference guide to the key points in the policy. However, we saw that whilst concerns were fully investigated and acted upon they were not always reported to the local authority or CQC when they needed to be. For example, there was one incident in April 2018 that was not reported and one more recent incident that had been treated as a medicine error when it should have been reported as a safeguarding concern.

At the time of the inspection there were enough staff to keep people safe and meet people's needs. One relative told us, "There seem to be more staff in recent months which is good." Staff did not appear rushed and people were being supported to engage in activities. The service used a dependency tool to work out the numbers of care workers needed. There were vacancies at the service and the service was using regular agency staff to support staffing levels. Staff were doing overtime at the time of the inspection and there was a welfare system in place to ensure that staff were not working more hours than they could do safely. The provider was actively seeking to recruit more staff to reduce the need to rely on overtime and agency staff but told us that they found this challenging. A number of staff had left the service since the last inspection. The provider told us that they wrote to staff who had left to invite them to consider returning and that some staff had done so.

There was a recruitment process in place to ensure staff were suitable to work with people before they started. Pre-employment checks were carried out; these included obtaining a full employment history, identification checks, references from previous employers and Disclosure and Barring Service (DBS) checks. A DBS check helps employers to identify people who are unsuitable to work with adults in vulnerable settings. The service also received information relating to agency staff to ensure that the appropriate checks had been undertaken for these staff.

When things went wrong lessons were learnt and improvements were made. People had complex needs and there could be a high number of incidents which needed to be recorded and shared with relevant health and social care professionals and people's relatives. Incidents and accidents were recorded by staff and were investigated. Where action was needed we saw that this had been undertaken. For example, one person had choked whilst eating a certain food and had been referred to the speech and language team for an assessment of their swallow to ensure that the service had up to date information on what the person could eat safely. Information was analysed for trends and where these were identified the service had taken

action. For example, the provider had identified that there were a number of incidents relating to moving and handling and had introduced new training. The service had continued to monitor trends and saw the number of incidents reduced.

Risks to people from the environment were well managed. People were protected from risks in the environment including the risks from fire. Staff continued to carry out regular health and safety checks of the environment to make sure it was safe. Where assessments had identified actions were needed these had been done. This was recorded in the maintenance log and action had been taken and recorded. One relative told us, "The home is generally well maintained." The provider had arranged for regular servicing of the electric hard wiring to make sure they worked safely and correctly. There was no gas at the service.

Regular checks were carried out on the fire alarm, emergency lighting and other fire equipment to make sure they were working properly and there were regular fire drills including a drill undertaken during the night time. People had a personal emergency evacuation plan in place which set out the specific requirements that each person has, to ensure they could be safely evacuated from the service in the event of an emergency.
There was a significant amount of equipment at the service such as hoists and suction machines which had all been serviced as appropriate. The hydrotherapy pool was regularly checked to ensure that the PH levels and chemical levels were correct. On the first day of the inspection the pool was closed as testing had identified that some adjustments were needed, these were undertaken, and the pool was open on the second day of the inspection.

Good

Is the service effective?

Our findings

Before people moved in to the service or came for a period of respite an assessment of their needs had been completed. The assessment was carried out by a manager and a nurse made follow up telephone call if more detailed information was needed when developing the care plan for the person. The service used a number of nationally recognised assessment tools as part of the assessment process. For example, a Waterlow assessment was completed for people. This is a tool that enables staff to assess the risks to a person's skin integrity and of developing pressure areas. Assessments included information such as peoples care needs, moving and handling needs, continence support, communication and nutritional needs. There was also information on people's cultural and spiritual needs and support they wanted to maintain their sexuality and sexual identity. For example, there was information on how people liked to dress.

Staff had the training they needed to support people. Training was a mixture of face to face and DVD courses and included manual handling, equality and diversity, fire, first aid, infection control and health and safety. Staff also completed training specific to people's needs such as behaviour support, oxygen therapy and suctioning, swallowing awareness and tissue viability. The staff we spoke to were positive about the training and told us that it was good. One member of staff told us, "There are lots of different training, we recently did an updated safeguarding training. I feel confident in my role and could have more training if I asked for it." The nursing staff we spoke to were also positive about the training they had received at the service and it was appropriate for their role. One relative told us, "The staff are well trained and if we have any suggestions regarding our [relatives] care, the staff listen to us and take it on board."

When new staff joined the service, they completed an induction which included completing mandatory training and shadowing more experienced members of staff. New staff were also appointed a buddy to support them whilst they settled in to the service.

The management team checked how staff were performing through one to one supervisions and an annual appraisal of staff's work performance. Nurses attended clinical supervision meetings where they could discuss people's nursing needs. Staff confirmed they had opportunities to meet with their manager to discuss their work, performance, training and development needs. Since the last inspection the management team had introduced competency assessments to make sure that staff performed manual handling safely and medicine administration safely. Staff and records confirmed that these had taken place.

People at the service had complex nutritional needs and some people received their nutrition through a feeding tube. This is a tube which goes directly in to the stomach through which people receive a liquid food. Where people had a feeding tube their food was planned by a dietician and the nursing staff ensured that people received this food as prescribed. Where people ate orally there was a menu in place which the kitchen staff told us have been selected based on nutritional value. Staff fed back people's reactions to the food to the chef who adjusted the menu to take these in to account. When people expressed that they did not like a certain dish we saw that they had been offered an alternative to what was on the menu. A number of people at the service had a long-term condition that caused them to be bloated on a regular basis and the service was working with a dietician to try and identify a menu which would reduce this from occurring.

Where people were at risk of choking they had been referred to the speech and language team (SaLT) for an assessment of their swallow so that the service had information on how people could best be supported to eat safely. There was clear guidance in place for staff to follow where people were at risk of choking. In order to support people to eat safely there was a protected meal time system in place. This meant that the dining area was closed off to other people and staff when people were eating so that the staff who were supporting people to eat were not distracted. Some people had very complex support plans in place to ensure that they could eat safely, when this was the case the number of staff who supported them was limited to those that knew the person and their needs best to reduce the risk of error.

We saw that staff worked together to support each other to deliver effective care. At the end of each shift there were handover meetings where staff discussed the events of their shift and shared information. People had hospital passports in place. Hospital passports contain information that is useful when people are admitted to hospital such as how people communicate and their care needs. Where people needed support from other health care professionals we saw that referrals had been made as appropriate.

People had accessed a wide range of services from other health care professionals. On the first day of the inspection we met an OT who was supporting one person to access a specially made car seat to enable them to travel safely. People's relatives told us that they had access to their GP when they were unwell and saw the dentist. One relative told us, "My relative's weight is well monitored, and the dietician has had input as well. The opticians come into the home. They are very good." One health and social professional told us, "The staff take on board what I teach them. The staff are very friendly and follow up on my instructions."

Both Martha House and Frances house were single level buildings which meant that everyone's bedroom was on the ground floor. People's rooms were personalised to their own taste and relatives had been involved in decorating areas of the service. The buildings were large and spacious, and people could move about with ease. Doors were wide enough for people's wheel chairs to fit through and there was level access to the gardens which appeared to be well maintained. Areas of the garden had been covered in a safe surface which enabled people to move around easier but reduced the risk of harm if there was an accident. Due to people's complex needs the service had significant amount of large equipment such as shower beds and adapted chairs which were in bathrooms and corridors. Some staff told us that they felt that both houses were getting "more cluttered." Although the corridors were wide enough to accommodate this equipment and we saw that there was still plenty of room for people using wheel chairs to move about safely this had an impact on how homely the service felt and was an area where the service could improve.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). Where DoLS were needed we saw that these had been applied for appropriately.

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. Staff had received training in the MCA and people did not appear to be restricted during the inspection and were free to move about the service with support from staff. Where people needed support to make

complex decisions we saw that best interest's meetings had been held and people's relatives were involved where appropriate.

Good

Is the service caring?

Our findings

We saw that staff treated people with kindness and compassion. People's relatives told us, "I think the staff treat my [relative] with care and with respect." Another relative said, "The staff are inclusive and open minded." A third relative told us about a time when they had seen staff out with some people and said, "I was impressed with the way the staff fully engaged with the service users throughout the time they were there."

When staff spoke to people they did so in a kind manner and moved in to a position where their face was at the same level as the person they were speaking to. A health and social care professional told us, "Staff chat with and include individuals with everything they do." One person was listening to an audio book in the lounge and needed some support from staff. The staff member spoke to the person prior to assisting them and continued to communicate with the person whilst they were providing them with the support. There were other people in the lounge, so the staff member lent in and spoke to them quietly so that other people could not hear, and the support was provided in a discreet way which protected the persons dignity. When we observed staff supporting people to eat we saw everyone seemed to be enjoying their meal. It was a relaxed atmosphere, everyone was taking their time, and there was general chat and laughter between staff and people throughout. The staff maintained good eye contact with the person when they were supporting them to eat.

The staff at the service were actively developing ways to support people to express their views and be more involved in decisions about their care. Since the last inspection the service had commenced a communication project. The aim of this work was to find ways to support people to access new ways of communication and communicate to their full potential. The service was in the process of introducing technology which could enable some people to communicate using eye movement. The technology was complex and took time to introduce as people and staff had to learn to use it and the work was still in it's infancy. At the time of the inspection two people had access to their own system and four people were being assessed to see if the technology was suitable for them using a shared system. Some staff had learnt to use the system and others were still learning. One person was using the system to express their preferences and make choices clearly for the first time. Another person had been able to have a conversation with their family for the first time. Staff told us that it was good to see technology beginning to be used more at the service and wanted to see people use this more and more staff become proficient at using the technology. Relative said, "My [relative] is able to make choices using [the technology] such as, what clothes to wear, what activity to do." Another relative wrote to the service and said, "The management team have been very supportive and are continuing to support work on improving communication not just for [my relative] but for all of the other residents.' The communication project was also researching other communication systems such as tactile solutions to improve communication opportunities for people who lived with a visual impairment and could not use eye movement technology. When people were not using these new methods to communicate staff understood people's gestures and words. For example, one person had an assessment tool which helped staff identify if the person was distressed or unhappy.

Through improving people's opportunities to communicate staff were also supporting people to become

more independent and make choices for themselves. For example, one person indicated to staff that they wanted to be left alone and staff arranged for them to be able to do so safely. The person had one to one support so that staff member waited in the corridor so that they were on hand to provide support when needed but the person could enjoy spending time alone in their room. People were also supported to be involved in the activities of daily living where possible such as cleaning their own room and putting away laundry. Staff told us they would find ways to involve people with tasks such as cleaning out drawers and taking their own washing to their room.

We saw that people's privacy and dignity were respected. When people needed personal care, this was provided in their room or the bathroom as appropriate. Relatives told us, "They respect her dignity by closing doors when they are giving personal care." And, "The staff put the curtains round if they are doing personal care, and chat to [my relative] telling them what they are going to do."

Records and information about people were kept securely in a locked cabinet in an office in each building. The service was working according to the Accessible Information Standard (AIS) and its requirements. AIS is a framework put in place in August 2016 making it a legal requirement for providers to ensure people with a disability or sensory loss can access and understand information. For example, information was provided verbally and was available in picture format where this could be used.

Good

Is the service responsive?

Our findings

At the previous inspection we found that a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user. At this inspection we found that care plans had been updated regularly although there were some concerns relating to the transition between paper care plans and electronic plans. Staff knew people well and understood people's preferences and we saw that care was delivered in a person-centred way. For example, one person's care plan stated that they needed to sleep with their head raised, we checked with staff who showed how the persons bed was raised at night to make sure that they were not lying flat. Another person needed their vital signs checked regularly to ensure that they were well, and we saw that this was completed.

At the last inspection there was a concern that care plans stated 'check people regularly', however, there was no guidance about what the term 'regularly' meant for that person. At this inspection we found that this had improved as the new electronic care plans had been introduced. Staff used hand held electronic devices which prompted them to complete tasks and recorded when the tasks were completed. Nursing staff were able to review these tasks to see if they had been completed when they needed to be.

There was information in people's care plans about the activities they liked to participate in or had been recommended for therapeutical purposes by health and social care professionals. One person had been supported by staff to go shopping which was something they enjoyed and proudly showed us the items they had purchased. Staff spoke to the person positively about this activity and the person was happy. People had one to one time when this was needed to engage in activities. There was an onsite hydro-therapy pool which we saw people accessing and enjoying. There was also a sensory room which we did not see used during the inspection. People were enjoying massage, manicures, listening to audio books and using technology to play games. We saw one person interacting with a large TV screen. When the person touched the screen with their arm, new images or sounds appeared. The person could choose to touch it when they wanted, and staff encouraged them to do so. The person was enjoying the activity and was following the images with their eyes across the screen. Relatives told us that people went on trips out. One relative said, "[My relative] likes to sleep and relax, which they are allowed to do here. They like the sensory room; the pool and went on a boat trip." A health and social care professional told us, "I feel this service goes out of its way to encourage inclusion and access to activities both at the home and in the local community."

People were being supported to maintain relationships with the people that were close to them. Relatives told us that they were able to visit when they wanted to do so. One relative said, "The staff are great. They always come and say hello if I have taken my [my relative] out into town and bump into them. They are her friends."

There was an easy read complaints policy on display at the service. Some people's relatives told us that they had complained. One relative told us, "I have complained, and it was dealt with in a timely manner and in a way that I was satisfied with. I feel that I am valued as a parent and am listened to." We looked at the complaints log and saw that complaints made to the service had been investigated and acted upon. Where

changes were needed to people's care or care plans these had been made.

There was a lead nurse to support people to plan for the end of their life. Staff had completed end of life training and had supported one person during this time since the last inspection. The service had sought support from the local hospice to help the person die at home as was their wish. When the person died other people were asked if they wanted to attend the funeral and some people were supported to attend. There was information in people's care plans about what they wanted to happen to them and their possessions after they had died, and the service was working with some families to discuss funeral plans. Some people had do not resuscitate orders in their care plans (DNR's). The DNR's we looked at were up to date. Other people had information about who needed to be consulted before a DNR was put in place to ensure that these decisions involved important people in their lives.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we found that 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 was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. At this inspection we found that there continued to be some concerns.

Quality audits had been completed to monitor and assess the service. Following the last inspection, the service had introduced a new audit framework. These included auditing care plans, medicines, infection control and health and safety. However, checks had not identified the issues we found at this inspection. For example, staff were not recording fluid intake in a consistent manner. Electronic care plans had been reviewed recently however the paper care plans had not been updated regularly and were still being used by staff. The service was in the process of transitioning from paper care plans to electronic care plans. During the transition paper records were still being used by staff and were supposed to be kept up to date. For example, one person had a fall. Mitigations had been put in place to prevent this from happening again, but the paper records had not been updated and the paper risk assessment was last updated in July 2018. The staff at the service had been using the electronic system to record fluid intake for 3 weeks. However, audits had not identified that staff were recording fluid in an inconsistent way. There was a grab bag in the medicine room which contained items which could be used in the event of an emergency. Audits had not identified that the instant ice pack contained in this bag had expired in 2015.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The provider had not ensured that the systems in place to check the quality of the care being provided were effective.

Notifications had not always been sent to CQC. These notifications would tell us about any important events that had happened in the service. We use this information to monitor the service and to check how events had been handled. This demonstrated the management team had not understood their legal obligations. There were incidents that should have been reported as safeguarding concerns to CQC and the local authority. The management team had not informed CQC or the local authority about two incidents one in April 2018 and one in November 2018 where medicine was administered to the wrong person.

The provider had failed to ensure that notifications were submitted to CQC when there was a notifiable event. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager had not de-registered with CQC but had left the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service told us that the director of operations intended to register as the new manager and at the time of the inspection had commenced the process of making an application.

The service had a clear vision for the future and had development plans in place to enable them to work towards this. This included improving safeguarding, developing communication and improving people's lives where they had a long-term condition. Staff told us that they were happy working at the service and were proud of their work. Staff said that they received regular supervisions and appraisals and were supported in their role. The nursing staff said they had access to clinical supervision support and were supported to complete their revalidation to remain registered as nurses. There were opportunities for staff to feedback on their experience of the service and the support they provided to people. There were also opportunities for staff to develop in their role and some staff had done so. For example, the kitchen supervisor had started at the service as a kitchen assistant.

Relatives, staff and professionals were invited to provide feedback annually via questionnaires. Where comments had been made or feedback was not always positive an action plan had been developed to make improvements. For example, relatives told us that communication was good, and they were kept informed of changes or incidents that happened. One relative said, "I am included in any decisions about her care. I receive updates by email." However, feedback via the questionnaire was not always positive about communication. We also saw that there were occasions where we saw that communication could be improved. For example, relatives had raised the concern that people's clothes went missing when they were washed. The service was in the process of recruiting a housekeeper to improve this situation. However, relatives were not aware of this. Some staff also told us that communication could be improved. The service had set up a communication group for staff and had changed the structure of the management team to address concerns. The service had identified that communication was an area for improvement. A non-clinical deputy role had been introduced to improve communication and the service was planning to introduce a new electronic communication tool for relatives once the electronic care plans had been fully introduced. There were also regular meetings for staff including nurse's meetings, house meetings, joint house meetings.

The management team had an oversight of accidents and incidents. Incidents and accidents were reviewed for trends and action was taken where it was needed.

The management team worked with social workers, occupational therapists, dieticians and other health professionals to increase learning and improve best practice. The management team had attended relevant conferences and was working with Rett UK to improve the lives of people living with this condition. One health and social care professional told us, "I feel that in the last year the service has greatly improved in their responses to recommendations."

It is a legal requirement that a provider's latest CQC 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 judgments. We found the provider had clearly displayed their rating at the service and on their 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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed ensure that notifications were submitted to CQC when there was a notifiable event.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that the systems in place to check the quality of the care being provided were effective.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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 do all that was reasonably possible to mitigate risks to people's health and safety. Medicines were not always managed safely.

The enforcement action we took:

We served a warning notice to ensure the provider took action to comply with the Regulation.