

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

This inspection took place on 19 July 2016 and was unannounced.

Martha House provides nursing and personal care and accommodation for up to 23 young adults with profound and multiple learning and physical disabilities. There were 20 people living at the service and one person on respite care during the inspection. People were unable to communicate verbally and used body language, facial expressions and some vocal sounds to make their needs known. There are two buildings in the service, Martha House and Frances House. Both premises are arranged over one floor, containing bedrooms, communal lounges and dining areas. All of the bedrooms are spacious, with hoist systems in place. The shared toilets and bathrooms also have hoist systems in place. There is parking available on site, and there are other facilities in the complex, including a hydrotherapy pool.

A registered manager was no longer leading the service. An acting manager had been appointed and was leading the service. They had applied to CQC to be registered as the manager of the service and were awaiting the outcome of their application at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There were two deputy managers one based in each of the houses, together with senior staff and they assisted with the inspection process.

At the previous unannounced comprehensive inspection of this service on 6 and 7 May 2015, five breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We undertook this inspection to check that they had followed their plan and to confirm that they now met legal requirements. At the time of this inspection the provider has complied with the breaches and had met their legal requirements.

Staff had received safeguarding training to protect people and they knew the action to take in the event of any suspicion of abuse. They had a good understanding of how to keep people safe and their responsibilities for reporting any concerns. Systems were in place to ensure that people's finances were protected.

Risks to people were identified and there were measures in place to reduce risks to keep them as safe as possible. Accidents and incidents were recorded and reviewed to identify if there were any patterns or if lessons could be learned to support people more effectively to ensure their safety. Plans were in place to keep people safe in an emergency.

Checks were carried out to ensure the premises were safe, such as fire safety checks, water temperatures and health and safety. Equipment to support people with their mobility, such as the ceiling hoists had been serviced to ensure that they were safe to use.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. The needs of the people had been taken into account when deciding how many staff were required on each shift. Staff told us the training programme was on going and the manager had ensured their training and development needs had been discussed through regular supervision and their yearly appraisal.

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role.

Peoples' medicines were managed and administered safely. However further detail was required to ensure 'as and when' medicines were given in line with people's needs. This was an area for improvement.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). When people lacked the mental capacity to make decisions the staff were guided by the principles of the MCA to ensure any specific decisions were made in the person's best interests. Some people living at the service had DoLS authorisations in place. People were supported to make decisions and choices.

People's dietary needs and preferences were documented. Staff understood people's complex dietary needs and promoted people to eat as independently as possible. The home's chef kept a record of people's needs, likes and dislikes which required further detail to ensure current information was up to date. This was an area for improvement.

Personalised care plans were in place and reviewed regularly. People's healthcare needs were monitored and appropriate advice sought from health care professionals to make sure people remained as healthy as possible. Family members supported their relatives and were involved in their care planning and all aspects of their lives.

People had the opportunity to participate in a varied activity programme. A system to receive, record, investigate complaints was in place, which showed complaints had been responded to appropriately. The service was reviewing the complaints policy with a view to implementing an easy read version. The complaints procedure was not on display to ensure that people were aware of the process. This was an area for improvement.

Staff told us that the service had improved since the previous inspection due to the new manager. They told us that they had good leadership skills and they were developing the staff to have the skills and knowledge to carry out their role. Staff told us they were supported very well by the manager.

Relatives, health care professionals and staff had the opportunity to voice their opinions through annual surveys, forums and meetings. There were quality assurance systems in place and these were being used to monitor and improve standards of care delivery.

There was a mission statement on display in the service, which outlined the visions and values of the service, such as treating everyone with dignity and respect, supporting and encouraging, and treating people with compassion. Staff were aware of these values and demonstrated their understanding of how to achieve this by offering people choice, treating them with dignity and responding to their needs. The manager was aware of, and had been submitting notifications to CQC in an appropriate and timely manner in line with CQC guidelines.

## 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.

People were protected against the risks of potential abuse.

Risks to people were identified and there were measures in place to reduce risks to keep people as safe as possible. Checks were in place to make sure the premises were safe.

There were enough staff deployed to ensure people received the care they needed and staff were recruited safely.

Medicines were stored safely, administered to people and handled appropriately, however guidance was required to ensure people received their 'as and when' medicines safely.

### Is the service effective?

Good ●

The service was effective.

Staff followed the principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. Staff offered people choices in ways they understood.

Staff had the training and development to provide the care and support people needed.

People were offered food and drinks they liked to help keep them as healthy as possible.

People were supported to maintain good health and had access to health care professionals when needed.

### Is the service caring?

Good ●

The service was caring.

Staff communicated with people in a caring and compassionate way. Staff knew people well and were knowledgeable about their daily routines and the support they needed.

Staff were kind to people, and spent individual time with them.

People were encouraged and supported to maintain their independence. Staff promoted people's dignity and treated them with respect.

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

### Is the service responsive?

Good ●

The service was responsive.

People were supported by their relatives when planning their care. Care plans were personalised with clear guidance of how to support people with their care. They had been reviewed to ensure all staff were up to date with people's current needs.

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

Systems were in place to resolve any concerns people had. Action was taken to make sure complaints were resolved to people's satisfaction. However, the complaints procedure was not on display or in an accessible easy read format.

### Is the service well-led?

Good ●

The service was well led.

The managers and staff were committed to providing a good quality service and promoted strong values and a person centred culture.

Staff had clear roles and responsibilities and were accountable for their actions. The manager and staff shared the provider's vision of a good quality service.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home.

Records were secure and stored appropriately.

# Martha House

## **Detailed findings**

### Background to this inspection

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

This inspection took place on 19 July 2015 and was unannounced. The inspection was carried out by two inspectors.

Before the inspection we reviewed the Provider Information Record (PIR) and previous inspection reports. The PIR is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications we had received from the service. Notifications are information we receive from the service when significant events happen, like a serious injury.

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

We last inspected Martha House in May 2015. At that time we found that the registered provider was in breach of five regulations.

# Is the service safe?

## Our findings

People were relaxed in the company of staff and indicated they felt safe. Guidance was provided about how to support people to feel safe and reduce the risk of them becoming anxious or worried. Staff supported people to avoid situations, such as loud noises that made them anxious. The majority of relatives said the service was safe. They said: "I am confident that my relative is safe and getting everything they need. They have everything in place to keep them safe" and "We have an arrangement that if (my relative) is anxious or upset and nothing they try works then they call me and I visit and that usually sorts everything out".

Health care professionals commented: "When required the service works closely with the local authority safeguarding team" "I believe, that in general, the staff at Martha House try their best to ensure that people are kept free from harm as much as possible".

At our last inspection in May 2015 the provider had failed to make sure that there was sufficient guidance for staff to follow to show how risks were mitigated when moving people. There was no effective procedure in place to ensure that emergency medicine was available when needed in a reasonable time without posing a risk and staff were not following procedures about managing medicines, including those related to infection control. The provider sent us an action plan telling us how they were going to improve. At this inspection we found that improvements had been made and action had been taken to ensure risk assessments contained clear measures to guide staff how to manage risks.

All of the people living at the service needed support with their mobility. Risk assessments recorded with detailed information the equipment to be used, such as handling belts, hoists and wheelchairs. There was clear guidance of how to move people in line with their medical conditions and step by step instructions to follow to ensure people were moved safely and consistently. Detailed guidance was available for staff to refer to such as what colour and size hoist sling to use, where to place people's legs and how to move them safely. There were also detailed risk assessments in place to support people living with epilepsy, choking and how to keep people safe when they were in bed and when they were doing activities. Some people were at risk of not drinking enough. The assessments did not identify how much fluid people should be aiming to drink daily. Staff were recording when the person had drinks but this was not added up at the end of each day to monitor if the person had enough to drink. This was an area for improvement. The staff took immediate action to rectify this issue.

Care plans contained information and how decisions had been made to support people to take their medicines. When people were needed to have the tablets with their food or drink guidance was in place to show staff how to do this safely. We observed that one person's medicine was placed on the spoon with their meal. Staff told the person the tablets were there and the person was able to take them safely. Care plans detailed people's medicine regimes, one care plan stated 'I take most medicines orally on a spoon with a drink. I am usually compliant as long as I know they are there. Please remind me to swallow my medicines rather than chewing them. Do this by tapping the cup in my hand gently and letting me 'swish them down'. We observed this person taking their medicine in line with the guidance in the care plan.

Peoples' medicines were managed and administered safely. Medicine pots and syringes for drawing up liquid medicines were reused and a system to ensure this was in line with infection control measures was in place. There were clear guidelines of how to ensure people who needed to be supported to eat through a tube in their stomach were managed safely.

Staff were trained to manage people's medicines safely. Their competency was regularly checked to make sure their practice remained safe. Accurate records were kept of the medicines people were given, including creams and sprays to protect their skin from getting sore.

Medicines were stored securely. Regular checks were carried out on medicines and the records to make sure they were correct. The temperature of the medicine room was recorded to make sure medicines were being stored at the correct temperature and were safe to use.

There was an epilepsy care plan in place for staff to give people their 'rescue' medicine if they had a seizure out in the community with the care staff. A clear individual protocol was in place for each person and staff had been trained how to give people this medicine should a person suffer a seizure.

There were guidelines in the care plan to show what signs people exhibited if they needed pain relief, or other as and when medicines. However there was no information to guide staff when the person should receive the medicine. There was a risk that people may receive their 'when required' medicines inconsistently. This was an area for improvement.

At the previous inspection in May 2015 medicine pots and syringes for drawing up liquid medicines were reused. There was no indication of how long they had been in use. At this inspection improvements had been made. When people had PEG feeding tubes (A 'PEG' is a Percutaneous endoscopic gastrostomy which is when a feeding tube is inserted directly into the person's stomach when they cannot maintain adequate nutrition with oral intake) the syringes used to push the liquids through the tube were changed every week. After each use they were washed with water and left to air dry. People's individual bowls for the syringes and pots which were dated to make sure staff knew that they had been cleaned after use.

A health care professional commented: "As a result of this concern the service put measures in place to ensure that staff received additional training and improved knowledge in PEG feeding, and infection control issues".

Staff had received training on how to keep people safe and knew how to contact outside agencies such as the local safeguarding team. Staff knew people well and were able to recognise signs if people were upset or unhappy. They were confident to raise any issues with the nurse or manager. They told us they would be listened to and appropriate action would be taken. Any incidents which needed to be raised as a safeguarding alert had been processed and the organisation had followed the correct procedures to make sure people were safeguarded against the risk of harm. Staff were aware of the whistle blowing policy and understood they would be protected and confidentially upheld should the need arise to raise concerns about other members of staff. When people had accidents, incidents or near misses these were recorded and monitored to look for developing trends. This included unexplained marks or bruising.

The provider employed suitable numbers of staff to care for people safely. They assessed people's needs and made sure that there were enough staff with the right skills to ensure people's needs were met. The planning of the staff rota took into account people who required one to one support and at times additional staff had been allocated when people needed additional support such as attending health care appointments.

Health care professionals commented: "I believe the one to one hours are allocated each day and this is improving along with better assessments of need. If a one to one activity had not been provided as a staff member was not trained to support a person, then action had been taken to increase staff numbers to be trained and provide the service".

The staff rota showed that there were consistent numbers of staff available throughout the day and night to make sure people received the care and support that they needed. Staff told us that there was always cover in time of sickness or annual leave. They said that shifts were covered by permanent staff or agency staff. The staff rota showed that when agency staff covered they tried to use the same agency staff for continuity of care to people. The manager was in the process of recruiting new staff to fill the vacancies. Staff told us that there was enough staff on duty which could fluctuate due to the complex needs of people using the service. There was an on call system in place should staff require guidance or in case of an emergency. The manager had taken action when it was identified that staff practice may have fallen below the required standard and appropriate disciplinary action had been taken.

The human resources department were responsible for recruitment. There were systems in place to recruit new staff. The service followed safe recruitment practices. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. All nurses' registration (PIN) numbers were regularly checked to ensure that the nurse was on the active register of the Nursing and Midwifery Council (NMC). Staff records did not always have a photograph of the employee on file. This is an area for improvement.

Plans for each person were in place to safely evacuate the building in the event of an emergency. Regular checks were carried out on the fire alarms and other fire equipment to make sure it was working. Regular health and safety checks were carried out to ensure that the premises were safe, for example the servicing of the equipment, such as hoists, wheelchairs and emergency lighting. The garden was well maintained, with areas of decking where people could sit in the warmer weather. An Incident and Business Continuity plan was in place with clear instructions to staff about how to deal with emergencies such as fire or adverse weather conditions.

The staff carried out regular health and safety checks of the environment and equipment. This made sure that people lived in a safe environment and that equipment was safe to use. These included ensuring that all of the moving and handling equipment, including the hoists were serviced and in good working order. People had special equipment to support their mobility needs, such as specially made wheel chairs, which were also checked and cleaned on a regular basis.

## Is the service effective?

### Our findings

People indicated that the staff looked after them well and the staff knew what to do to make sure they had everything they needed. People had a wide range of needs. People's conditions were complex.

Most relatives spoke positively about staff and told us they had the skills to meet their relative's needs. They said, "The staff spend a lot of time really listening, watching and understanding people" and "The key is good communication between everyone and this happens. We all work together to get what is best for (my relative). All the staff are very approachable" and "They are a happy staff team. I think the training is good. They all know what they are doing. They put a high emphasis on training the staff".

Other relatives said that the staff did not always listen to their opinions and that they did not communicate with each other. We did not find any evidence to confirm this at the time of the inspection.

At our last inspection in May 2015 the provider had failed to ensure the induction programme was preparing staff for their role. Further specialist training was required to ensure staff had the skills to fulfil the requirements of their role. Supervision and appraisals for all staff was not being provided to make sure staff development and competence was maintained. The provider had not acted in accordance with the Mental Capacity Act and associated code of practice. The provider sent us an action plan telling us how they were going to improve. At this inspection we found that improvements had been made. The induction training had improved; staff had received supervision and a yearly appraisal. People were being cared for in accordance with the Mental Capacity Act.

People were receiving care from staff that had regular supervision and an annual appraisal to discuss and improve their practice in order to develop their skills and meet people's needs.

Staff told us that the induction was thorough and linked to the Care Certificate. They said that they had shadowed the established staff for two weeks then met with a senior member of staff to find out if they felt confident to work on their own. There was a three month and a six month evaluation when staff competencies were assessed. A decision was then made on whether staff had the skills and knowledge to undertake their roles or if they needed more support before they became permanent staff. Nurses confirmed that a new induction programme was in place and new staff were supported to complete the programme.

All staff attended monthly house meetings where they could discuss the running of the service and any concerns. The staff told us that they thought the induction programme had improved and was more in depth. There was more face to face training. An external training provider gave six sessions of training over a twelve week period and also offered one to one support staff if required. Staff said they were moving away from DVD training and it was now only used for a few areas like food hygiene and health and safety.

All staff had a personal training record and received regular training updates, which included moving and handling, health and safety, infection control, safeguarding adults, mental capacity, food hygiene and fire safety. Some staff had also received specialist training, such as epilepsy, equality and diversity and

communication. In November 2015 the provider had introduced Profound and Multiple Learning Disability training (PMLD) for staff. This provided staff with an over view and introduction in order for them to have a better understanding of the people they were working with. Some nurses had received Enteral Tube Training in 2016, Tissue Viability Training, Inhaler, and Technique/Oxygen training. The nurses competencies were monitored and checked to make sure they had the knowledge and skills to deliver care and treatment effectively and safely

All levels of staff were receiving supervision. Staff said their supervision sessions had improved and were more beneficial than they were previously. Staff had a minimum of four supervision a year were they could discuss any concerns or issues. Areas for improvement and development were identified and staff worked towards these. Nursing staff were receiving clinical supervision with support from an external company. Clinical supervision supported the nurses to improve the quality of their practises, reflect on clinical practises, look at risk management and accountability and responsibility. The nurses meet monthly to discuss issues, new ideas, best practise and ways to improve. Nurses told us they found this beneficial and supportive.

Staff asked people for their consent before they offered support. This varied from people responding by eye contact and gestures to let them know their feelings. Staff knew people well and were able to tell us what people wanted or needed. People responded by smiling and looked comfortable in the presence of staff.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. The staff were aware of their responsibilities in relation to supporting people to make decisions and had received Mental Capacity Act training.

DoLS applications for all of the people living at the service had been authorised by the local authority and these were being regularly monitored and reviewed to ensure that any restrictions were in line with people's current needs.

Health care professionals commented: "I feel that, in general, the preferences and decisions, however small, that the person would make if they were able are reflected in their records. The best interest's decisions which have been made under MCA guidance and legislation have reflected the needs of the individual as much as possible".

People's capacity to consent to care and treatment, including the use of bed rails had been assessed and each restriction of a person's liberty had been considered and measured against proportionality of the response to the potential risk of harm. There was information to explain why each restriction was in the person's best interest. For example when a person needed to have medical treatment or make complex decisions about their care, this had been discussed with health care professionals, relatives and or an advocate to ensure that this decision was necessary in the person's best interest. Staff were aware of people's level of capacity.

People had access to health care professionals such as GP's, consultants, specialist nurses, dieticians, physiotherapists and speech and language therapists. People had regular appointments with chiropodists, dentists and opticians. Care plans had clear details of how to support people if they required further support with their physiotherapy treatment and how to carry out the exercises.

People living with epilepsy had care plans and charts in their plan to monitor their seizures with detailed guidance for staff to follow in the event of a seizure. People who had difficulty communicating verbally were seen by the speech and language therapists so other ways of communicating could be explored. People saw their doctor when required and the nurses attended hospital appointments with consultants. Staff told us how beneficial this had been as they had a better understanding of the person's complex medical needs which had resulted in a more detailed and effective care plan. A relative commented: 'The nurse is a hero; they add great value to attending major clinics with my relative'.

Specialist nursing 'profiling' beds were provided, which supported people to keep their skin healthy and special cushions were available for people to sit on. Care plans had guidance on how to monitor people's skin to reduce the risk of pressure areas. This included re-positioning in bed and having afternoon bed rest. There were body maps and bruise charts to ensure that staff were aware of any vulnerable areas.

Some relatives raised concerns about the diet their loved ones were receiving. We contacted the speech and language therapist (SALT) who assessed people about what type of food they needed. They told us that there was ongoing support from the team and the service regularly had support and guidance to ensure that people received the care they needed. We spoke with the manager and staff and they were knowledgeable about people's dietary needs.

Health care professionals told us that communication was good with the service and they were contacted for advice or guidance if needed. They said that the service acted on their advice to ensure the person received the care they needed.

Nutritional risk assessments were completed to make sure people were receiving the food they needed. Some people had complex nutritional needs and had been involved with health care professionals to ensure they received a healthy diet. People needed food that was prepared specially for them. The consistency and texture of people's food varied depending on their needs. The manager told us that the chef's and the care staff were jointly responsible to make sure the food was as it should be. Carers knew what type of diet people needed to receive and would report back to the chef if the consistency of the food was not according to the person's assessment and guidelines. People's weights were recorded and any significant changes were reported to senior staff for action and referral to a health care professional. Food and fluid charts were in place to monitor people's dietary needs and this information was used to assess if people needed further nutrition such as food supplement drinks.

We observed the lunch time meal and staff supporting people to eat. Staff checked people's food and drinking guidelines at each meal time to ensure that they had not changed. This was because they had complex dietary needs, such as thickening drinks or food. Staff ensured people who were able, were supported to eat independently. They spoke with people as they helped them to eat. One person had their food cut up on their special plate to ensure their independence would be maintained and they were able to manage themselves. Two people would not eat their meal. Staff told us that this happened on occasions and in these circumstances they would ask the person to go to their bedroom and try again. This was because they sometimes preferred a quiet place to eat. This was recorded in their care plan. Both people went to their rooms where they ate all their lunch.

We spoke with the chef regarding the menus and choices available. They were able to tell us details of people's preferences and dietary requirements, and this information was more detailed in individual care plans, however the records of people's likes and dislikes was not fully completed. This was an area for improvement. The deputy manager told us that a meeting would be held with the kitchen staff to ensure that systems were put in place to address these issues.

Families were encouraged to be involved with their relative's food and this was discussed at the family forum in May 2016. The service had introduced a menu analyser which would calculate salt/fat/calories etc., once the menu had been put into the system. Families were also invited to email the manager with their suggestions or ideas. People were involved with sensory cooking sessions which were organised by the activities co-ordinator.

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

A day centre, sensory room, computer room, art room and hydrotherapy pool facilities were also available. At the time of the inspection the hydrotherapy pool was not available as there technical problems. There was a sensory garden with decking and raised beds. The garden and decking was easily accessible to people, and was well maintained.

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

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

# Is the service caring?

## Our findings

People indicated they thought the staff were caring and that they liked staff. People were very relaxed and comfortable in their home and with the staff that supported them. People communicated with the staff through noises, body language and gestures and staff knew what they saying and asking and responded to their requests.

Most relatives told us the service was caring. They said, "The standard of care is excellent. My relative is well cared for. We are not people who would say something is good when it's not". "Staff feel like part of the family".

Relatives told us they felt very involved in their loved ones care, they said the staff asked for their opinions all the time and acted on their suggestions and ideas.

Health care professional commented: "Staff use communication techniques appropriate to the individual, such as touch, eye contact and speech to understand what people need". "I feel that care is given to ensure that the needs, wishes, feelings and preferences of the person are taken into consideration".

The manger and staff were committed to providing good quality care to people living at the service. They were passionate about upholding people's rights and choices. Staff told us the team was caring and how they enjoyed their work. They said: "This is the best job I have ever had". "I look forward to coming to work to help and support the people who live here". "It's a great place to work". "This is the best place I have ever worked in". "We really do the best to care for everyone; we make sure each person has a right to live as an individual". "People here are like our family"

Staff showed concern for people's wellbeing in a caring and meaningful way, and they responded to their needs quickly. For example one person did not like loud noises and staff realised they were getting anxious. The noise level in the service was reduced and one member of staff sat with the person talking to them until they became calm and relaxed.

People's records included information about their personal circumstances and how they wished to be supported. This enabled staff to speak with them about who and what as important to them.

People had a regular keyworker and co-key workers to support them. A keyworker is a named member of staff that was responsible for ensuring people's care needs were met. They build up personal relationships with people to get to know them better. Staff knew people's individual communication skills, abilities and preferences. There was a range of ways used to make sure people were able to say how they felt about the caring approach of the service. People responded with eye contact, smiling or with gestures, such as touching hands or arms. Staff listened and observed people; they were patient and gave people time to respond to them.

The relationships between staff and people receiving support demonstrated dignity and respect. Staff

talked to people constantly telling them what they were going and asking them what they preferred to be doing. When people seemed anxious staff were not rushed and took time to talk and sit with them. A staff member said: "We support people's rights to choose and treat people with dignity and respect".

Staff were observed saying thank you to people when they carried out tasks, such as putting their shoes on. They chatted to each person as they carried out their daily routines such as walking to the dining room table for lunch. They encouraged them to communicate and to make meal times a sociable occasion. People's hands were refreshed with wipes before lunch and staff spoke with people reassuringly when they needed to support with their mobility.

Staff told us how they supported people with their personal care, whilst respecting their privacy and dignity. This included explaining to people what they were doing before they carried out each personal care task. Care plans detailed people's preferences and choices, for example one person's plan stated how to choose their clothes and what they liked to wear.

Staff knew, understood and responded to each person's diverse cultural, gender and spiritual needs in a caring and compassionate way. Each Monday people were invited to attend a prayer meeting. This decision had been discussed with people and their family to ensure this was acceptable practice. The majority of the people joined this meeting; however one person had decided they did not wish to go and their decisions had been respected.

People's bedrooms were personalised with their photographs and what was important to them. Their bedrooms reflected people's personalities, preferences and choices. Some people liked to stay in their rooms for 'quiet time' or to listen to music, this was respected and this was happening during the inspection.

Most people were supported by their family members when they needed to make decisions and advocacy services were being used to support some people in the service. An advocate is someone who supports a person to make sure their views are heard and their rights upheld. ensure that people had the support they needed.

Visitors were welcome in the service. Some relatives visited the home on a daily basis and people were also supported to make visits to their families.

## Is the service responsive?

### Our findings

People were supported to be involved in the care and treatment that they needed. The staff worked around their wishes and preferences on a daily basis. People indicated to staff about the care and support they wanted and how they preferred to have things done. Relatives said that the service was responsive to their relatives changing needs.

Relatives said, "The staff know the complexity and difficulties of (my relatives) condition and how quickly things can change. We have a fabulous nurse who has made sure they know everything about the condition. They attend all the appointments with the specialist. We don't think anyone could do it better".

Relatives told how their loved ones condition had improved. Staff had found triggers to their seizures, their diet had been modified and they were doing more exercise and were supported to walk for short periods. Staff had carried out passive exercises on a person's arm that they had not been able to move for many years. The person now had movement their arm.

Relatives told us about the holidays people had recently been on. They said, "Residents are encouraged to do more things outside the home. (My relative) and some of their friends went to Centre Parks recently and had the best time ever. Staff gave up their own time to do this" and "If you look at holistic practise, it's fantastic at Martha House".

At our last inspection in May 2015 the provider had failed to ensure that person centred care and treatment was meeting the needs of people using the service and plans had not all been reviewed or updated. At this inspection we found that improvements had been made and person centred care planning had been implemented and care plans had been reviewed and updated.

When people first came to live at the service they had a care and support assessment to identify their needs. From this information an individual care plan was developed to give staff the guidance and information they needed to look after the person. One person was in the process of moving to the service and was visiting on different occasions to have a meal and stay overnight. Their family had been involved in the process and supported them to pick the colour their room is to be painted. This helped staff to get to know them and the person was given the opportunity to decide if they wanted to live at Martha House.

The service was implementing a new format of care planning. The new format contained detailed information about people's needs, such as their individual needs assessments, personal care, nutrition, skin care, medical conditions, health care plans, risk assessments, likes and dislikes. For example, when people needed further support with their nutritional needs, the care plans had a detailed nutritional assessment and their likes and dislikes were recorded. There was guidance on how the person managed to swallow, what equipment they may need to use and risk assessments were in place to guide staff how to reduce the risk of choking and what to do in case of an emergency. The person's weight was monitored and recorded and food and fluid charts were in place to ensure they were receiving the nutrition they needed. Details of support from health care professionals and their recommendations had been recorded to ensure staff had

the current guidance.

People's personal care needs were detailed to their choices and preferences. The care plans detailed what the person could do for themselves such as 'I am able to wash and can reach with encouragement if I have hand over hand support'. Records also showed what preferences in toiletries they used and what creams or body lotions they preferred.

How people preferred to communicate was detailed for each person in their care plan. The plans stated how people communicated either verbally with expressions or gestures. One care plan described that they responded better to jovial conversations and simple instructions. Staff demonstrated that they understood about people's behaviours and supported people in a positive way. This was through getting to know and understand people's needs. Guidance was in place to consistently minimise anxieties that could trigger such an incident, such as encouraging people to listen to their music and relax in the privacy of their own room.

People's care plans were reviewed regular by their named nurse and the keyworker staff member was involved in the reviews to ensure any changes to people's needs were taken into account. People who were unable to communicate using speech, used body language, signs and facial expressions to let staff know how they were feeling. Staff were aware of people's individual ways of communication and monitored people's body language and facial expressions to identify any changes in their health and well-being.

Staff told us that the care plans had improved and although very detailed gave clear guidelines of how people should be cared for and supported. Verbal daily handovers from senior staff took place at the beginning of every shift to keep all staff up to date with people's current needs. Staff told us they reported any changes to people's behaviour or health to the nurse on duty and action was always taken promptly to address the issues.

Relatives had varied views about activities that were provided. Some relatives told us that people did not do enough activities and would benefit from doing more. Other relatives thought their loved one had an active life. They said that the activities provided by the provider in the activities centre was developing and evolving and people were supported and encouraged to do more outside the service.

Health care professionals commented: "Keyworkers support people with their activities linked to their likes and choices and some people had just returned from a holiday."

The service offered therapy programmes including physiotherapy, reflexology, massage and music therapy which were tailored to each person's individual need. The service had a hydro pool with a high tech lighting system to encourage people to relax in the water, whilst enjoying sounds and music. At the time of the inspection the hydrotherapy pool was out of action due to health and safety reasons. The service had informed relatives and stakeholders of this issue at the family forum in May 2016. Since then the manager had arranged a maintenance contract to regularly maintain the pool to ensure it was safe to use. The timescale for completion was approximately two weeks. Additional staff training had been taken place and staffing levels were to ensure three members of staff would be on duty to support people in the pool.

A full programme of activities are also on offer including sensory cooking, arts-and-crafts and music and there were regular activities and days out like horse riding, bowling and trips to the cinema.

In Frances House there was a section in the kitchen which was adapted so people could take part in sensory cooking. People were able to attend the day centre which was located within the grounds of the service, and were also supported to go out and have meals in the local town. The garden has been designed with raised

beds to encourage people to enjoy the experience of gardening. There were areas of shade and seating with a large fish pond to relax and enjoy.

There was also a large screen touch computer available. One of the directors of the organisation told us that they had managed to raise sufficient funds to order and install a 'magic' carpet' sensory system. This tool enabled people to interact through movement or eye contact. People could then experience images such as moving fish in a pond, or scattering stars. The learning tool could be tailored to individual abilities and needs so that people had an opportunity to engage with people of all ages and abilities.

People were offered the opportunity to access the community by going to local groups and clubs, gardening, and outings in the local community. The mini bus was insured for families to drive if they needed transport to access the community. The statement of purpose informed people that Martha Trust had a Christian ethos and aims to support people in their beliefs. There were regular prayer meetings and the service was supported by the local vicar.

People had complex needs and some people were not able to express their views easily. Care plans had guides in place to show how people exhibited behaviour if they were unhappy or anxious. Staff told us that they knew if people were not well and that something was wrong. They said they noticed changes in people's behaviour and would report this to the senior on duty.

People's concerns and complaints were encouraged, investigated and responded to in good time. The service had a written complaints procedure which was not written in a way that people could understand. The manager told us that this was in the process of being discussed and they were looking at ways to enable people to raise their concerns. They gave an example of how they had monitored a person's moods and behaviour to assess what was wrong and if they could do things differently to ensure the person was happy.

## Is the service well-led?

### Our findings

Relatives said: "All the staff are more involved now. They work as a team and feel more valued" and "Since the new manager arrived there have been great improvements. The two deputy managers and made changes for the better. It feels like it's all coming together". "I see the manager when I need to but mainly deal with the deputies. The manager is there when you need them".

Health care professionals commented: "I would recommend a family member to this service. They don't always get it right but I feel they do work hard to improve things if something goes wrong. They actively seek ways of continually improving the way in which they work and accept suggestions for improvements". "There was a homely feel to the service and a calm atmosphere, and I would feel comfortable to recommend a family member".

At our last inspection in May 2015 the provider had failed to ensure that the systems in place to quality assure the care being provided were not effective. Feedback was not being gathered from all stakeholders to improve the quality of the service and records were not completed properly or accurately. At this inspection we found that improvements had been made and effective systems were in place to quality monitor the service and gather information from all stakeholders to improve the service.

The provider had a quality assurance system to monitor the quality and safety of the service and to identify any areas for improvement. A wide range of audits were carried out. The manager, deputy manager and staff audited aspects of care monthly such as medicines, care plans, health and safety, infection control, fire safety and equipment. These also covered housekeeping, the kitchen environment, hand washing and checking the first aid kit. When any areas for improvement had been identified, these had been acted on. One audit had identified that some care plans had not been reviewed and updated to the standard that was required. Action had been taken to address this issue.

The service produced a newsletter twice a year to ensure that people were kept up to date with events and fund raising ideas to support the people living at Martha and Frances House. This included pictures of people who had chosen to contribute to the news.

Staff told us that they had received one to one meetings with their line manager (supervision) this included clinical supervisions for the nursing staff and their training and development had been discussed to enhance their skills. Staff said they had been encouraged to complete or apply for vocational qualifications to improve their competences. A health care professional commented: "Staff are encouraged to speak up if they feel they need additional support and guidance".

There were regular team meetings and staff told us their views and opinions were listened to. They said they felt valued, worked as a team and morale was high. Each month the nurses had a meeting to discuss the service and how to continually improve the service. The nurses told us that this had been extremely effective and they were able to provide consistent care and support to people. They said that this ensured everyone was aware of any changes such as the new medicine regime. Staff had confidence the manager would listen

to their concerns and would be received openly and dealt with appropriately.

Accidents and incidents had been recorded, reviewed and monitored by the Chief Executive Officer and there was evidence through emails to show that that appropriate action was being taken to reduce the risk of further or similar occurrences.

The recording of all information had improved with detailed care plans in place which reflected the care being provided. Documents had been reviewed signed and dated. Records had improved and were completed properly. Systems were in place to ensure that outcomes of people's health care appointments were recorded. Nurses and key worker staff told us that it was their responsibility to make sure this had been done. Charts to monitor daily dietary needs had been completed but had not always been totalled to evaluate the outcomes. This was an area for improvement.

The provider sought the views of relatives by holding regular family forums where relatives had the opportunity to voice their opinions of the service. Minutes showed how open discussions took place with regard to equipment, redecoration of the service, fundraising and forthcoming events. Relatives said that the family forum was improving and becoming more structured. They said things were getting done and changing for the better. One parent said "There is now a vision for the future". There were also regular house meetings with people and their key workers to discuss the care being provided.

There were systems in place to actively seek the views of a range of stakeholders, staff, or visiting professionals which should be used to drive improvements to the quality of the service. The most recent survey was carried out in February 2016. Shortfalls had been identified and action was being taken to make improvements.

The trustees of the organisation also met on a regular basis, there were systems in place to show how they monitored the continuous improvement of the service.

A registered manager was no longer leading the service. An acting manager had been appointed and was leading the service. They had applied to CQC to be registered as the manager of the service and were waiting the outcome of their application at the time of the inspection. Since the previous inspection the management structure had been changed and there was a deputy manager in Frances House and in Martha House. There was always a nurse on duty in each house with senior staff and care staff. There were also human resources and administration staff within the complex. Each nurse had been given a lead role within the organisation such as the lead for medical conditions, moving and handling or mentoring student nurses. Relatives stated, "Since the appointment of the acting manager there have been great improvements", they also said that the appointments of the deputy managers has been a 'god send'. They said that communication had improved and overall the service was improving.

All of the staff we spoke with told us that the service had improved since the new manager was appointed. They said that they had good leadership skills, motivated staff and were passionate about providing good quality care to the people living at Martha and Frances House.

Staff told us that they felt supported by the manager. One member of staff told us the manager gave them direction and guidance to perform their role. They said this applied to praise for good practice and constructive advice when something was wrong and needed to be improved. They said: "Since the appointment of the new manager the service have improved one thousand per cent. They have supported and motivated staff to work as a team, everybody knows what is expected, and I have complete confidence in them". "They have an overall understanding of the service group and have good communication and

interactive skills". "The manager is fabulous, they are visible on the floor and everything has improved". "There have been a lot of changes since the new manager came, the service has improved and is much better now".

The organisation's visions and values were on display, which included treating everyone with dignity and respect, supporting and encouraging, we show compassion to everyone at the service and to each other. Staff were aware of this ethos and spoke about people in a dignified manner. They stressed the importance of treating people with dignity and respect, whilst respecting people's personal wishes and beliefs.

The manager attended local network meetings and provider forums to help stay on top of best practice. They were associated with support from the Men cap Organisation and members of the Kent Integrated Care Alliance to ensure they were aware of changes to current practice and to keep up with changes to in the health care sector.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. This meant we could check that appropriate action had been taken. The registered manager was aware that they had to inform CQC of significant events in a timely way. We had received notifications from the home in the last 12 months. This was because important events that affected people had occurred at the service.