Martha Trust Hereford Limited

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?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 1 and 3 May 2018. The first day of our inspection visit was unannounced.

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

Martha House accommodates up to 14 people within one purpose-built building, and specialises in the care of people with learning and physical disabilities. At the time of our inspection visit, there were 13 people living at the home.

A registered manager was in post and present during our inspection. 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 our last inspection in December 2016 we rated the home as Good. At this inspection we found the service remained Good overall, although there were some areas where improvements were required

Discrepancies identified by staff during the home's weekly medicines count had not always been investigated to confirm people had received their medicines as prescribed. The provider had failed to notify us of the authorisation of two people's Deprivation of Liberty Safeguards applications, as required under their registration with CQC.

People were supported by staff who understood how to recognise and report any form of abuse or discrimination. The risks associated with people's care and support needs had been assessed, recorded and plans implemented to manage these. Staffing levels meant people's individual needs could be met safely. All prospective staff were subject to pre-employment checks to ensure they were suitable to support the people living at the home. Measures were in place to protect people from the risk of infection, including appropriate use of personal protective equipment (PPE) by staff.

People's individual needs and requirements were assessed before they moved into the home. Staff received relevant training and ongoing support to ensure they had the skills and knowledge needed to work safely and effectively. People received encouragement and physical assistance to eat and drink, and any associated risks were managed. Staff helped people to access a range of healthcare services to ensure their health needs were monitored and met. People's rights under the Mental Capacity Act 2005 were understood and promoted.

Staff had taken the time to get to know people well, and adopted a kind and caring approach towards their work. Staff and management encouraged people to express their views and be involved in decision-making

that affected them. People were treated with dignity and respect.

People received consistent, personalised care that reflected their individual needs and requirements. The provider's complaints procedure promoted good complaints handling.

The management team promoted open communication with people, their relatives and the community professionals involved in their care. Staff benefited from effective leadership and were clear what was expected of them. The provider took steps to involve people, their relatives and staff in the service, and welcomed their views.

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.

Staff knew how to recognise and report abuse. The registered manager monitored and organised the home's staffing requirements based upon people's individual needs. People received their medicines from trained nurses and care staff. Staff made appropriate use of personal protective equipment to protect people from infection.

Is the service effective?

Good

The service was effective.

Staff had the training and ongoing support needed to deliver effective care and support. Any complex needs or risks associated with people's eating and drinking had been assessed, recorded and managed. Staff played a positive role in ensuring people's health needs were met. People's rights under the Mental Capacity Act 2005 were understood and protected.

Is the service caring?

Good

The service was caring.

People were supported by staff who knew them well and who encouraged them to express their views. People were treated in a respectful and dignified manner and able to receive visitors at the home when they chose.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support, tailored to their individual needs and requirements. People's relatives knew how to raise concerns with the provider, and had confidence these would be acted upon.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Discrepancies identified during the weekly medicines count had not been consistently investigated to ensure people had received their medicines as prescribed. The provider had failed to notify us of the authorisation of two people's Deprivation of Liberty (DoLS) applications, in accordance with their registration with us. The provider's quality assurance was not as effective as it needed to be. The management team promoted an open and inclusive culture within the service. Staff felt able to approach the management team for additional support at any time.

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 checked 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.

The inspection took place on 1 and 3 May 2018. The first day of the inspection visit was unannounced.

The inspection team consisted of one inspector.

Before the inspection site visit, we reviewed the information we held about the service, including any statutory notifications received from the provider. A statutory notification is information about important events, which the provider is required to send us by law. We also contacted the local authority, the local clinical commissioning group (CCG) and local Healthwatch for their views on the service.

Over the course of our inspection visits, we spoke with one person who used the service, seven relatives, three community healthcare professionals and two professionals within the provider's in-house multi-disciplinary therapy team. In addition, we spoke with a founding trustee, the provider's director of care, the quality assurance auditor, the registered manager, the deputy manager, the cook, one nurse, two senior care staff and five care staff.

We looked at a range of documentation, including two people's care files, medicines records, incident and accident reports, three staff recruitment records, staff training records, complaints records, selected policies and procedures, certification related to the safety of the premises and records associated with the provider's quality assurance.

Good

Is the service safe?

Our findings

At the time of our last inspection we rated the Safe key question as Good. At this inspection we found the service remained Good.

One person told us they felt safe living at Martha House, describing the staff that supported them as "lovely". People's relatives expressed confidence in the safety of the care and support their family members received at the home. One relative explained, "The attitude and dedication of the care staff gives you confidence … We are going away on holiday soon and have no reservations [about leaving family member]." Another relative told us, "I am one hundred percent satisfied with the safety of the care at Martha House. We visit once a week and the standard of the service is faultless."

The provider had taken steps to protect people from abuse and discrimination. Staff received training and support, from their induction onwards, to help them understand and fulfil their individual responsibility to identify and report any form of abuse or discrimination involving the people who lived at the home. Staff recognised the different forms and potential signs of abuse, and were clear about how to raise any concerns of this nature with the provider. One staff member told us, "I'd go straight to [deputy manager], [registered manager] or [director of care], and we can always ring the on-call manager if we are ever concerned about anything or need advice." The provider had procedures in place designed to ensure any witnessed or suspected abuse was reported to the appropriate external agencies, and investigated. Our records showed they had previously made notifications to CQC in accordance with these procedures. We saw recent safeguarding issues at the service had been subject to investigation, and action had been taken to keep people safe.

The risks associated with people's individual care and support needs had been assessed, recorded in their care files, and kept under regular review by the nurses. This process took into consideration key areas of risk, such as people's long-term health conditions, their mobility, nutrition, and any specialist care equipment they used. Documented plans were in place to manage identified risks and keep people as safe as possible. For example, epilepsy management plans had been developed, with appropriate specialist advice, to provide staff with clear guidance on the management of people's epilepsy, including the expected use of their seizure rescue medications.

Staff told us they were given the opportunity to read people's risk assessments, and they showed good insight into the agreed management of the specific risks to individuals. They received a range of training on how to work safely, including health and safety, fire safety and first aid training. We saw staff adhered to safe work practices as, for example, they made safe and appropriate use of mobility equipment to carry out transfers and help people move around their home. Staff explained they were kept up to date with any changes in the risks to people through, amongst other things, attending daily 'handovers' at the start of their shifts 'Handover' is a face-to-face meeting in which the nurse leaving duty passes on key information about any changes in people's needs or circumstances to staff arriving on shift. One staff member told us, "I think the communication is quite good. Whoever's handing over to you will have a more in-depth discussion with you if you are assigned to work with that person."

Events where people were involved in an accident, incident or 'near miss', or any unexplained injuries, were noted and reported on by staff. . The management team and provider monitored these reports on an ongoing basis, conducting further investigations, where necessary, and taking action to minimise the risk of reoccurrence. A member of staff explained, "They [quality assurance auditor] will ask us what we can do to stop things from happening again." For example, following an accident involving a piece of specialist care equipment, the provider had fitted improved safety rails to this equipment, and had stipulated two members of staff must be present at all times when it was in use.

The provider had a dedicated maintenance team and carried out, or arranged, regular safety checks, to ensure the premises and equipment were suitable and safe for use. This included regular tests on the home's fire alarm system, electrical and gas safety checks, and the inspection and servicing of people's care equipment.

People's relatives and staff confirmed staffing arrangements at the service meant people's individual needs could be met safely. The registered manager explained that staffing levels were assessed and organised in line with people's current care and support needs. We saw there were enough staff on duty to provide people with the one-to-one support needed to ensure their safety and wellbeing. The provider carried out checks on all prospective staff to ensure they were safe to work with people. This included obtaining employment references and an enhanced Disclosure and Barring Service (DBS) check. The DBS searches police records and barred list information to help employers make safer recruitment decisions.

We looked at how the provider sought to ensure people's medicines were handled and administered safely. People's medicines were stored securely, at all times, either in a locked medication trolley or locked medicines cabinets. They were administered by trained nurses, with support, when required, from trained care staff. The nurses and care staff responsible for administering people's medicines maintained up-to-date medicine administration records. They sought people's permission to administer their medicines, confirmed they had taken these, and were clear about the action to take in the event of a medication error or refusal. The nurses carried out a weekly stock count on people's medicines, to confirm people had received their medicines as prescribed, and that their medicines were being safely handled. However, discrepancies identified during this stock count, had not always been investigated by the management team.

The provider had taken steps to protect people from the risk of infection. They employed domestic staff who supported care staff in ensuring the equipment and premises remained clean and hygienic, through following daily cleaning schedules. Staff received training on infection prevention and control, and made appropriate use of the personal protective equipment provided, such as disposable aprons and gloves. The provider's quality assurance auditor completed six-monthly audits on infection control practices at the service, enabling the provider to identify and address any potential areas for improvement.

Good

Is the service effective?

Our findings

At the time of our last inspection we rated the Effective key question as Good. At this inspection we found the service remained Good.

Before people moved into Martha House, the registered manager met with them, their relatives and staff from their current care placement to assess their individual needs and requirements. The purpose of this was to enable the provider to establish whether people's needs could be safely and effectively met by the service, and, if so, to develop effective care plans to achieve positive outcomes for people. Once people were at the home, use was made of a wide range of specialist care equipment to enhance the care and support provided. This included mobile beds, ceiling track and mobile hoists, custom moulded wheelchairs and other specialist seating. One relative explained, "If they [provider] think equipment is suitable for people, they will bring it in; they don't hold back."

People's relatives felt staff had the right knowledge and skills to meet their family members' individual needs. One relative told us, "They [staff] are generally well trained and caring." Another relative said, "I think they [staff] have good training on people's needs before they are allowed to work on their own." Upon starting work at the home, all new staff completed the provider's induction training, to help them understand and settle into their roles. During the induction period, staff were supported by a mentor, worked alongside more experienced colleagues, completed initial training and competency checks, and were given time to read people's care plans. One staff member explained, "It [induction] was thorough. I had 20 shifts of shadowing with every single resident. You get to know residents well and how to do your job." The provider's induction incorporated the requirements of the Care Certificate, which is a set of nationally-recognised standards that should be covered in the induction of new care staff.

Having completed their induction, staff participated in a rolling programme of training, which reflected their duties and responsibilities and the needs of the people living at Martha House. For nursing staff, this included support with revalidation and the opportunity to attend training days at the local hospital. Additional external training was sourced from the local hospice and other bespoke training providers. Staff spoke positively about the effectiveness of their training with the provider, and appreciated the fact that this was tailored to the specific needs of the people they supported. One staff member explained, "All the training is done in-house and it is face-to-face. It is aimed at the people we work with, so it makes more sense." Another staff member spoke about the particular benefits of the epilepsy training they had attended during their last 'clinical training day'. This, they explained, had given them hands-on experience and confidence in the safe administration of people's rescue medicines.

In addition to formal training, staff attended regular one-to-one meetings, 'supervisions', with a senior colleague. During these meetings, staff were able to raise any work-related issues, received feedback on their work performance and discussed any additional training or support they may need. One staff member told us, "They [supervisor] ask me if I am happy in my job and whether they can help me. They go through my training and any problems I am having."

People's relatives praised the quality of the food and drink provided to their family members who lived at the home. One relative told us, "The diet they [people] have is wonderful; their nutritional needs are met really well." People were supported to have a balanced diet. Any complex needs or risks associated with people's eating and drinking were assessed by the in-house speech and language therapist, recorded and plans put in place to manage these. This included the provision of texture-modified diets and the use of thickeners in drinks to address people's swallowing difficulties. One relative, whose family member required a specialist diet, told us, "They [provider] meet [person's] dietary needs 150 percent; they are absolutely stunning … They go out of their way to get organic produce."

Mealtimes were flexible, social occasions during which people could choose where they wanted to eat, and were given alternatives, based upon their known food preferences, if they did not want the meal on offer. Laminated 'meal-cards', which were stored appropriately when not in use, reminded staff of each person's needs and preferences during mealtimes. We saw staff gave people the individual attention and physical assistance they needed to eat and drink comfortably and safely, making use of appropriating eating and drinking aids.

Staff and management understood the need to work collaboratively with external professionals, teams and organisations to ensure people received coordinated care and support, and took steps to achieve this. For example, when people were admitted to hospital, the service worked closely with the hospital's learning disability liaison nurse to ensure their needs were understood and met throughout their admission. The service had also signed up to the NHS's 'red bag scheme' to facilitate a smoother handover between the service and ambulance and hospital staff. This involved care staff packing a dedicated red bag containing the individual's key paperwork and medication along with clothing and other personal items to accompany them during their hospital stay.

Staff and management liaised with, and helped people to access, a wide range of healthcare services and professionals to ensure their health needs were met. This included local GPs, consultants and specialist nurses, and the provider's in-house multi-disciplinary team. The latter included a physiotherapist, speech and language therapist, and an occupational therapist. People's care plans clearly explained the role staff had to play in monitoring and addressing their day-to-day health needs, including the management of health conditions such as epilepsy, diabetes and asthma. The healthcare professionals we spoke with confirmed they received appropriate referrals from the service, and that their recommendations and advice were followed by staff and management.

The overall design and adaptation of the purpose-built premises ensured staff were able meet people's individual needs safely and effectively. Onsite facilities included two sensory rooms, a soft-play area, and a therapy suite which incorporated a hydrotherapy pool and 'rebound therapy' trampoline. Rebound therapy involves the use of trampolines to provide therapeutic exercises to people with a wide variety of disabilities and additional needs. We saw people had easy access to the home's gardens, and suitable space to meet in private with visitors or spend time alone if they chose to. People's relatives confirmed the provider involved them and their family members in decisions about changes or improvements to the home's environment. This included the recently-completed refurbishment of the hydrotherapy pool, physiotherapy room and redecoration of the soft play area.

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.

We checked whether the service was working in line with the principles of the MCA. People and relatives told us, and we saw, staff sought people's consent before providing their routine care and support. Staff showed good insight into people's rights under the MCA, including the need to encourage people's day-to-day decision-making and to respect people's choices. One staff member explained, "It's about their ability to make decisions and communicate them effectively. It [mental capacity] can vary from day-to-day." Staff described how they monitored people's non-verbal communication to understand their wishes and choices, and involved them in decisions, for example, about what they wore or how they spent their time. We saw mental capacity assessments had been completed for individuals in relation, for example, to decisions about the administration of medicines, therapeutic activities and the use of specialist care equipment. One relative praised the support staff and management had given them during a best-interests decision-making process around their family member's medical procedure. They told us, "They [staff and management] were so reassuring and they helped us through it … There was always a senior present during discussions with [medical professional]."

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw the management team had applied for DoLS authorisations based upon an individual assessment of people's capacity and their care and support arrangements. Where DoLS authorisations had been granted, the registered manager understood the need to review and comply with any associated conditions on these.

Good

Is the service caring?

Our findings

At the time of our last inspection we rated the Caring key question as Good. At this inspection we found the service remained Good.

One person told us staff treated them well, adding "I like living here." People's relatives felt staff and management adopted a kind and compassionate approach towards their work. Two people's relatives described how staff had gone the extra mile by supporting their family members throughout their most recent hospital admissions. One of these relatives said, "They [staff] are absolutely fabulous … They go above and beyond, but see it as being part of their job." Another relative said, "It's clear to me that staff's commitment to [person] here is an extension of what they had at home."

Staff had developed positive rapport with the people they supported, and showed good insight into people's personalities, and their individual needs and requirements. They greeted people warmly upon seeing them for the first time that day, engaged them in friendly conversation and prioritised people's comfort and wellbeing. When providing people with direct care and support, such as physical assistance to eat during mealtimes, they did so in a patient and attentive manner, and interacted well with people throughout the activity. People appeared at ease in the presence of the staff supporting them, and we saw people laughing and smiling in response to their interactions with staff. Staff demonstrated their concern for people's comfort and wellbeing. For example, when one person began to cough repeatedly, staff were quick to confirm whether they needed any assistance. Staff offered effective reassurance to another person who was a little nervous about attending a pantomime they had chosen to go to later that day.

People's care plans included detailed information about their communication needs, and guidance for staff on how to promote effective communication with each individual. The majority of the people living at the home were unable to communicate their needs and wishes verbally. Staff understood the importance of monitoring each individual's non-verbal communication in order to understand their choices and preferences. Under the guidance of the provider's speech and language therapist, and with appropriate training, staff employed different strategies to develop people's communication skills and so enhance their ability to express their views. This included a long-standing focus upon the use of 'Signalong': a sign-supported communication system based on British sign language. One relative told us, "Staff's communication with [person] is as good as can be."

People's relatives told us, and we saw, that staff treated their family members in a dignified and respectful manner at all times. One relative explained, "They [staff] always tell [person] what they are going to do … and they are always very careful to close doors [during intimate care]." People's relatives confirmed they were able to visit their family members at the home at any time. One relative told us, "I am always made to feel welcome and made a cup of tea." Staff recognised their responsibility to protect people's rights to privacy and dignity, and gave us further examples of how they achieved this on a day-to-day basis. These included being sensitive to people's feelings and anxieties, offering them choices at every opportunity and promoting their independence. One staff member told us, "We [staff] are constantly encouraging people to feed themselves." One person's relatives described the progress their family member had made in this area

of their life, explaining, "[Person] has started feeding themselves. They haven't done that for four or five years." Staff and management helped people to access independent advocacy services whenever they needed support to have their voices heard on particular issues, and one person was currently using such a service.

Good

Is the service responsive?

Our findings

At the time of our last inspection we rated the Responsive key question as Good. At this inspection we found the service remained Good.

People's relatives told us that their family members who lived at Martha House received a service shaped around their individual needs and preferences. One relative explained, "Everyone here is unique and they [staff and management] are able to respond to their unique requirements." In order to ensure that each person received consistent, personalised care, they were each allocated a named primary nurse and a senior care assistant to oversee and coordinate their care and support. To further promote continuity of care, people's day-to-day care and support was provided by a small group of designated care staff, who received additional guidance and support to understand their individual requirements. Throughout our inspection visit, we saw staff adjusting their communication and support to suit the individual, in line with their care plans and risk assessments.

People's relatives were fully satisfied with the extent to which they were involved in care planning and other decision-making affecting their family members' care at the home. One relative told us, "They [staff and management] don't just make a decision without involving us in it." Another relative said, "We feel part of it [the service]." People's relatives described the value of the annual care review meetings they attended at the service with their family members' care team, including the in-house therapists. One relative explained, "I like to come along and make lunch as a small way of saying thank you. We all have a chat about [person's] care and anyone there can raise issues."

People's care plans were individual to them and covered a wide range of topics and needs. These included people's physical health, emotional wellbeing, therapeutic regimes, communication, personal care and sexuality. Care plans took into account people's protected characteristics under the Equality Act 2010, including their religious beliefs. In addition to guidelines for staff on how to meet people's individual needs safely and effectively, care plans included key information about people's interests and preferences. All of the staff we spoke with confirmed they could easily access people's care plans, and that they had the time to refer to these as and when needed. One staff member explained, "We know exactly where the care plans are if we need to get one to have a quick refresher on the needs of residents we have not worked with for a while." Care plans were reviewed on a monthly basis, or sooner if required, by each individual's primary nurse, with the support of the person's designated senior care assistant, who produced a monthly report on their progress at the service.

One person told us they enjoyed going swimming in the home's hydrotherapy pool and playing 'eye-gaze' games in the home's sensory room. Eye-gaze technology is a way for people to access a computer or communication aids using a mouse they control with their eyes. People's relatives praised the range of therapies and social and recreational activities on offer at the home. One relative explained, "One of the great things about Martha House is they have so many therapies on offer; [person] is busy all the time. There's no risk of them sitting and looking at the TV set all day, which would mean nothing to them." They went on to describe how their family member had grown in confidence through using the home's eye-gaze

technology. An individualised programme of therapeutic and recreational activities had been developed for each person, which was followed on a flexible basis, giving priority to what people opted to do on a given day. During our inspection visits, we saw people participating in a range of activities and therapies. These included aromatherapy, music therapy, eye-gaze activities, attending a pantomime at an associated home, going for a walk around the local area and shopping in the city centre. The pantomime in question had been rearranged from Christmas due to the snow.

One person told us they would speak to staff if they were worried or upset about anything. People's relatives were clear on how to raise and concerns or complaints about their family members' care and support, and had confidence they would be listened to. One relative explained, "We have developed a good relationship with staff, and do raise issues with them as we're in and out every other day. When we do raise issues, they are generally happy to take our feelings on board." Another relative told us, "I don't think that in [number of] years [person] has been here, anyone has ever argued about looking into or doing something; they are always on our and [person's] side." The provider had a complaints procedure in place to ensure complaints were dealt in a fair and consistent basis. We looked at the most recent complaint received by the service, and found action had been taken to address the complainant's concerns. Where any concerns had been raised in relation to the conduct of individual staff members, these had been dealt with in line with the provider's disciplinary procedures.

At the time of our inspection, no one living at the home was receiving palliative or end-of-life care. The provider had procedures in place to identify people's wishes for their end-of-life care, with the input of their relatives, at the appropriate time.

Requires Improvement

Is the service well-led?

Our findings

At the time of our last inspection we rated the Well-led key question as Good. At this inspection we found improvements were required.

As part of the provider's quality assurance checks, the nurses carried out a weekly stock count on people's medicines, comparing the actual number or volume of each medicine against the expected stock, based upon people's medicine administration records. However, where discrepancies had been identified during this stock count, these had not always been investigated by the management team to ensure people had received their medicines as prescribed, and that their medicines were being safely handled. For example, on 30 January 2018, the weekly medicines stock count had identified nine discrepancies affecting a total of seven people's medicines. However, the home's records indicated that none of these discrepancies had been followed up. This does not reflect good practice in the management of people's medicines. By failing to promptly investigate all discrepancies, the provider could not be assured people had received their medicines as prescribed, or that people's medicines were being safely handled and administered.

The registered manager was unaware that discrepancies identified during the weekly medicines stock count were not always being investigated, but acknowledged this was not acceptable. They felt the deputy manager needed protected time each week to allow them to promptly follow up any such discrepancies. They took immediate steps to facilitate this through, amongst other things, rescheduling the weekly management team meeting. The registered manager had existing plans in place aimed at reducing the overall number of discrepancies occurring in relation to management of people's medicines. These included carrying out further competency checks on staff involved in the handling and administration of people's medicines.

Providers are required, under their registration with us to notify us when a Deprivation of Liberty Safeguards (DoLS) application is authorised for people who use their service. During our inspection visits, we found the management team had not notified us of two people's authorised DoLS applications. The registered manager explained they had been on long-term leave at the time these applications were granted, and the deputy manager had been unaware of the need to notify CQC in this regard. Our records showed the provider had submitted a previous notification of this nature to CQC, and other required notifications, in accordance with their registration with us. During our inspection visits, the registered manager took immediate steps to ensure the deputy manager was fully aware of events and incidents to be notified to CQC. Following our inspection visits, they submitted retrospective notifications to us in relation to the authorised DoLS applications in question.

Although the provider had established a rolling programme of audits and checks to monitor the quality and safety of the service, these had not enabled them to identify and address the shortfalls in quality we identified in relation to the management of people's medicines and submission of required notifications to CQC. The provider's quality assurance included audits targeted on the home's health and safety arrangements, infection prevention, kitchen hygiene and practices and moving and handling practices. These audits and checks had resulted in improvements in the service, including improved standards of

record-keeping and developments in staff training. The latter included the introduction of a 'senior staff development programme', geared towards helping senior care staff more fully understand, and fulfil, the key duties and responsibilities associated with their position.

The registered manager was responsible for the day-to-day management of the service, and demonstrated a clear understanding of the duties and responsibilities associated with their post. They felt they received the necessary support and resources from the provider to successfully manage and drive improvement in the service. They kept themselves up to date with legislative changes and current best practice guidelines by, amongst other things, pursuing further qualifications, and attending events run by the local clinical commissioning group (CCG), Royal College of Nursing study days and learning disabilities nursing conferences. The service's current CQC rating was clearly displayed at the premises, as the provider is required to do.

People's relatives were very satisfied with the overall management of the service, and the positive outcomes this had resulted in for their family members. One relative told us, "I can only say we're absolutely delighted with it [the service]. It's like winning the lottery. We never have to worry or fret about [person]. It's an amazing place." Another relative said, "They [staff and management] give [person] a quality of life we couldn't achieve on our own." It was evident, from speaking to people's relatives, staff and healthcare professionals, that the management team promoted an open and inclusive culture within the service. People's relatives had confidence in the open and transparent manner in which the service was run, and the willingness of the provider and management team to listen to, and act upon, their opinions. One relative explained, "They [provider] are very open about things; nothing is done under the table. They do listen to what we say and our opinions are taken into account." Another relative said, "They [management] listen to us and try to fit our wishes in with their protocols. They will discuss things with us and find the middle ground."

The provider's internal multi-disciplinary team and the community healthcare professionals we spoke with also described a positive and open working relationship with the home's management team. One healthcare professional told us, "They [management] are always very open to me coming here and completing reviews. They are happy to share information and documentation with me and generally act on my recommendations." They went on to say, "The home feels very much like a family, which is lovely."

Staff spoke about their work with the people who lived at Martha House with enthusiasm. One staff member told us, "I think it's a really nice organisation." Another staff member said, "Overall, it's a really nice home with a good aim." We saw staff were at ease in the presence of the management team, who maintained a visible presence around the home. Staff told us they were clear what was expected of them at work, and that the management team was approachable should they need any additional support or guidance. One staff member explained, "They [management] are really nice and friendly. They always have their doors open, so we can go and talk to them if we need to." Twenty-four hour on-call management support was also provided to respond to any urgent requests for support or advice staff may have outside of office hours. Staff had confidence in the management team's willingness to listen to them, and their ability to act on issues brought to their attention. One staff member told us, "If you raise any concerns, they [registered manager] will follow it up. I think they are a great manager. They are very thorough and they keep communicating with you." The provider had a whistleblowing policy in place, and staff told us they would follow this, if necessary. Whistleblowing refers to when an employee tells the authorities or the public that the organisation they are working for is doing something immoral or illegal.

The provider took steps to involve people, their relatives and staff in the service, and to invite their ideas and suggestions as to how the care and support provided could be further improved. The management team

organised regular staff meetings in order to consult with staff, provide them with an open forum to share their views and ideas and keep staff up-to-date with any planned changes to the service. Staff confirmed they felt able to have their say during these meetings. Annual feedback surveys were also sent out to staff and people's relatives, as a further means of capturing their views on the service. People's relatives confirmed they had received these surveys. One relative explained, "[Staff member] sends out the survey forms. We went in to see them, instead of filling it out, and had a really good meeting with them." People's relatives explained that the positive rapport they had developed with staff and management meant they were able to share their views and concerns with them at any time.