Review of compliance

Four Seasons Homes (Ilkeston) Limited Nottingham Neurodisability Service Hucknall - Millwood	
Region:	East Midlands
Location address:	Hankin Street Hucknall Nottingham Nottinghamshire NG15 7RR
Type of service:	Care home service with nursing
Date of Publication:	May 2012
Overview of the service:	Nottingham Neurodisability Service Hucknall - Millward is located in the Hucknall area of Nottingham. It offers accommodation for up to 22 people with physical disability. It is registered to care for people who need nursing or personal care and it provides nursing care.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Nottingham Neurodisability Service Hucknall - Millwood was meeting all the essential standards of quality and safety inspected.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 29 February 2012, talked to staff and talked to people who use services.

What people told us

The people we spoke with told us that their privacy was respected. They also said that staff showed them respect and that their dignity was maintained. They told us that staff ask about their needs, wishes and personal preferences and they felt that all their needs were met at Millward Unit. They felt that a range of suitable activities were offered.

We spoke with a person who told us they felt safe living at Millward Unit. People also told us that they were treated well by staff and that there were sufficient staff available to meet their needs.

The people we spoke with were positive about the quality of the service they received. One person told us, "[It's] good...excellent." They also felt they had some say in how the service was run.

What we found about the standards we reviewed and how well Nottingham Neurodisability Service Hucknall - Millwood was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People's privacy, dignity and independence were respected. Their views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Outcome 04: People should get safe and appropriate care that meets their needs

and supports their rights

People experienced care and support that met their needs and protected their rights.

Outcome 07: People should be protected from abuse and staff should respect their human rights

People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

There were enough qualified, skilled and experienced staff to meet people's needs.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We spoke with three people who use the service. They were not all fully able to tell us their experiences because of their complex needs. However, they all agreed that their privacy was respected and that staff showed them respect and ensured their dignity was maintained.

The people we spoke with had no recall of being involved in drawing up their care plans or risk assessments. However, one person told us that staff did ask about their needs and wishes. From this, and other evidence gathered, we understood that people were enabled to express their views and were involved in making decisions about their care.

Other evidence
We spoke with two members of staff at this inspection. They felt that they were given enough information about people's needs as soon as they were admitted to the service. They both considered that they were given enough time to read people's care plans to ensure they could represent their views. They told us that the people who use the service were regularly involved in considering and reviewing their individual care needs. One staff member described people's involvement in personal decision making and, periodically, the involvement of their relatives. We saw evidence of a relative being invited to a care plan review meeting. Staff confirmed that regular multi-disciplinary

meetings were held and that people who use the service were, wherever possible, involved in these.

We read two people's personal records and saw that they included a full assessment of their needs at the time of their admission. We found that care plans and risk assessments had been initiated soon after admission so that staff were aware of people's needs from the beginning. However, there were no signatures to confirm people's involvement in their care planning and we spoke with the acting unit manager about this. The provider may find it useful to consider ways of addressing this matter. We saw evidence, on people's files, of their dignity being considered and maintained.

We saw clipboards hanging outside each person's bedroom door. The acting unit manager explained these were used to attach notes made by night staff regarding whether people had experienced continence management problems during the night, for example. The provider might wish to consider whether this relatively public display of information may compromise people's dignity.

Staff described to us the ways they find out the views of people with communication difficulties. They used body language, discussion with colleagues and talking with family members. One staff member told us they had received training on the topic of communication with people with a head injury.

People were supported in promoting their independence. Staff gave us examples of how people's independence was enabled. These included prompting to undertake personal care tasks, physiotherapy activities in the therapy room, baking in the dining room and 'breakfast club' every other morning.

Our judgement
People's privacy, dignity and independence were respected. Their views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
The people we spoke with said that staff ask about their personal preferences and they felt that all their needs were met at Millward Unit. Most of the people felt that a range of suitable activities were offered and two people described examples of those activities they found stimulating. From this, and other evidence gathered, we understood that care was planned and delivered in a way that ensured people's welfare.

Other evidence
People's needs were assessed and care was planned and delivered in line with their individual care plan. We noted that individual care plans reflected people's personal preferences and showed that their health needs were well monitored. We found that staff took an approach, to the people who use the service, which was centred on their individual needs and this was reflected in their care plans. Recording was detailed and provided a clear picture of people's needs and how these were to be best met by staff. We found a range of risk assessments were being recorded and reviewed regularly. Staff showed awareness of the benefits of recording risk assessments as a way of identifying and minimising risks to the people who use the service. One staff member said, "I feel comfortable about risk assessments minimising risks."

We found recorded evidence that people's mental capacity was being considered in relation to their decision making and one staff was able to confirm appropriate levels of knowledge regarding this through discussion of an example. The provider may find it useful to note that the other staff member did not recall having received any training on these topics and was unclear about the concept of mental capacity. This lack of

understanding could lead to people's right, to make their own decisions, not being fully recognised.

Staff were positive about the range of person-centred activities provided to the people who use the service and they both thought these activities were valued by people. One staff member supported this by saying that people use residents' meetings to tell staff what activities they like. On the day of this inspection we saw four people going out with staff to a local cinema followed by lunch out. The service's full time activities coordinator had arranged this. One staff member said that people go out, "almost everyday."

Our judgement
People experienced care and support that met their needs and protected their rights.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
Only one person was able to tell us whether they felt safe living at Millward Unit. This person told us they did feel safe. Two people were able to tell us that they were treated well by staff.

Other evidence
Staff told us what they would do if they had concerns about abuse happening at Millward Unit. They had been provided with training on keeping vulnerable people safe. One staff member said they had also had training on safely restraining people and had not seen any form of restraint carried out. The other staff member told us that any potentially abusive incidents were recorded on an on-line incident form and we later saw examples of these.. We consider this good practice as patterns of abusive behaviour can be identified and measures taken to minimise it in future. The training matrix confirmed that the majority of staff had, within the previous 12 months, been provided with training on keeping vulnerable adults safe.

The acting unit manager was aware of the need to refer incidents, relating to actual or suspected abuse of people who use the service, to the local social services office. However, in our discussion with the acting unit manager and the centre manager we found that very few safeguarding referrals had actually been reported by staff at the service. This was because the criterion had been set quite high in relation to referring incidents of abuse between the people who use the service. The provider may find it useful to consider reviewing the criterion.

Our judgement
People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
Two of the people we spoke with felt there were sufficient staff to meet their needs and were readily available. They said that staff were competent at their job.

Other evidence
We asked the two members of staff whether they felt there were sufficient staff available to meet people's needs. They said there were and they also thought that people did not have to wait long for staff attention.

We read the previous week's staff rota and this confirmed the acting unit manager's description of staffing levels. These did not include any agency staff hours and we were told that the use of temporary staff, which the service could call on when the need arose, was kept down to one regular person. As well as nursing staff, senior care and care staff and a full time activities coordinator there were additional dedicated staff. These included two full time rehabilitation assistants and a full time psychology assistant. The acting unit manager said there were no staff vacancies and that the staff group was an experienced and stable one.

Our judgement
There were enough qualified, skilled and experienced staff to meet people's needs.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
The people we spoke with were positive about the quality of the service they received. One person told us, "[It's] good...excellent." They also felt they had some say in how the service was run. One person was able to tell us that residents' meetings were held and they found them useful.

Other evidence
The staff we spoke with told us that they had each been given responsibility for auditing one aspect of the service. They also confirmed there were audits undertaken by persons external to the service. Staff felt that they had a say in how the service was run and managed and they felt listened to. They told us that staff meetings were held every month and confirmed there was an open culture that allowed staff to feel supported to raise concerns without fear of recrimination. Staff also spoke of having one-to-one supervision with the manager every two months and annual personal development reviews.

Staff explained how the people who use the service can complain or how any concerns they may have are identified by staff if they are unable to verbalise these concerns. One staff member said, "We monitor residents' behaviour and document and look for patterns." The other member of staff told us, "We listen to, and watch, residents' behaviour for evidence of discontent."

People who use the service, and their representatives, were asked for their views about their care and these were acted upon. There were monthly meetings for the people

who use the service and meetings for their relatives three times a year. We read the minutes of the last residents' meeting held in April 2012 and these illustrated involvement from the people who use the service. There were also recorded action plans from the meeting.

Quality monitoring tools also in place included monthly staff meetings and quarterly visits by a manager from one of Nottingham Neurodisability Service's other care homes. We read the minutes of the last staff meeting held in March 2012: these covered a number of useful topics. Satisfaction questionnaires were sent to the people using the service and to their relatives. The provider may find it useful to note that the opinions of staff and visiting professionals were not being sought through surveys. The potential benefits of this were discussed with the centre manager. We also read a detailed business plan for 2012.

The registered provider's complaints procedure was clearly displayed. We saw a complaints record, which was clearly documented and followed up.

The centre manager described a comprehensive range of recorded environmental risk assessments.

Our judgement
The provider had an effective system to regularly assess and monitor the quality of service that people receive.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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Author	Care Quality Commission
Audience	The general public
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Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA