Review of compliance

The National Society for Epilepsy Milton House	
Region:	South East
Location address:	Chalfont Centre, Chalfont St Peter, Gerrards Cross, Bucks SL9 0RJ.
Type of service:	Care home service without nursing.
Date the review was completed:	02/02/2011
Overview of the service:	Milton House is one of a number of homes on the National Society for Epilepsy (NSE) site at Chalfont St Giles. It provides accommodation and personal care for up to 12 people with a physical disability and epilepsy. The accommodation is all on ground floor level with individual bedrooms and two lounges. There is comprehensive healthcare support available on site and from a local general practitioner. There are some facilities on site such as a small shop and cafe. Local shops are within walking distance. There is local transport to nearby towns.

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

What we found overall

We found that Milton House was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out the 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 the 2nd February 2011, observed how people were being cared for, talked to people who use services, talked to staff, checked the provider's records, and looked at records of people who use services. We also asked the provider to complete their own assessment of compliance against each of the essential standards (Provider Compliance Assessments)

What people told us

People who use the service told us that they were involved in decisions which affected them which included meal choices, activities and holidays.

They told us that their privacy and dignity was respected and that staff call them by their preferred name. Staff did not always knock prior to entering their bedrooms. One person told us that they would like to get up a bit later in the mornings but can go to bed at a time convenient to them.

People who use the service told us that they are consulted on their care and treatment. They told us that they were well looked after and that they received good care.

They told us that volunteers had recently become involved with the home to provide friendships for them. They told us they had access to some leisure activities but not as much as they would like.

People told us that the food was very good and they were given enough to eat and drink. They told us they were given a choice of two meals each day at lunch time.

They knew who to speak to if they felt they were being badly treated by staff and knew how to make a compliant. They told us that monthly house meetings took place which enabled them to raise issues that concerned them.

People told us that they liked living at the home, they felt it was kept clean and well maintained.

They told us that staff give them their medication and that they get it at the required time. People told us that they thought the home could do with more staff at certain times of the day and should employ more male staff. They are not involved in interviewing staff

People told us that they were anxious about recent staff changes. The registered manager had left and a new manager was due to start at the home. They told us that the new manager had been visiting the home and getting to know them

People told us that they thought the regular staff were well trained. They also said that the staff that come in at short notice were not and did not know what to do.

Staff told us that they felt they were well trained and supported, with regular supervision taking place. A bank worker told us she had a brief induction into the home.

What we found about the standards we reviewed and how well Milton House was meeting them

Outcome 1: 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 choices, confidentiality, privacy and dignity were not always promoted and respected.

- Overall, we found that improvements are needed for this essential standard.

Outcome 2: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

There were systems in place for people's consent to be sought However, it was not always clear if the person's capacity to consent had been assessed. While training was available on the Mental Capacity Act and the Deprivation of Liberty safeguards only a limited number of staff had completed this training.

- Overall, we found that improvements are needed for this essential standard.

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights

People were happy with the care and support they received. Although records did not demonstrate that care was delivered consistently, measures were in place to address these shortfalls.

- Overall, we found that Milton house was meeting this essential standard.

Outcome 5: Food and drink should meet people's individual dietary needs

People did not receive the support they required in a timely manner.

- Overall, we found that improvements are needed for this essential standard.

Outcome 6: People should get safe and coordinated care when they move between different services

Staff support people to obtain the health and specialist support they need

- Overall, we found that Milton house was meeting this essential standard.

Outcome 7: People should be protected from abuse and staff should respect their human rights

Systems were in place to protect people from abuse. However some staff practices, lack of specific guidance on the management of behaviours and lack of updates in safeguarding training could potentially put people at risk of harm or abuse.

- Overall, we found that improvements are needed for this essential standard.

Outcome 8: People should be cared for in a clean environment and protected from the risk of infection

People who use the service are protected by a good standard of hygiene and cleanliness.

- Overall, we found that Milton house was meeting this essential standard.

Outcome 9: People should be given the medicines they need when they need them, and in a safe way

People may not have their medications safely and as prescribed. This is because patterns of staff errors in medication administration are not addressed and guidance is not provided on the administration of as required medications.

- Overall, we found that improvements are needed for this essential standard.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

The overall design and layout of Milton house is suitable for the people who use the service.

Staff practice in relation to leaving the store cupboard insecure and lack of updates in fire training poses risks to the safety and well being of people who use the service.

- Overall, we found that improvements are needed for this essential standard.

Outcome 11: People should be safe from harm from unsafe or unsuitable equipment
People were provided with suitable equipment. There were systems in place to make sure that this was safely maintained.

- Overall, we found that Milton house was meeting this essential standard.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job
People who use the service could be assured that there were robust staff recruitment procedures in place.

- Overall, we found that Milton house was meeting this essential standard.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs
Shifts were not managed to ensure that sufficient staff were available to support people who use the service at peak times of the day.

- Overall, we found that improvements are needed for this essential standard.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills
People may not always be safe with their health and welfare needs met by competent staff. This is because although staff receive induction, training and supervision not all training is current. Neither do staff consistently apply what they have learnt.

- Overall, we found that improvements are needed for this essential standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care
Milton house had procedures in place for monitoring the quality of care experienced by people who use the service.

- Overall, we found that Milton house was meeting this essential standard.

Outcome 17: People should have their complaints listened to and acted on properly
Milton House had systems in place to enable people who use the service to raise complaints.

- Overall, we found that Milton house was meeting this essential standard.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

Milton house had systems in place to manage records to safeguard and protect people who use the service.

- Overall, we found that Milton house was meeting this essential standard.

Action we have asked the service to take

We found that the Milton House was fully complaint with 8 of the 16 essential standards of quality and safety.
For eight of the essential standards we are not satisfied that Milton House is compliant. We have six areas of minor concern and two areas of moderate concern that they are not compliant with essential standards.
We have set an improvement action and compliance action upon the Provider for these areas to be addressed.

We use a judgement framework, a document called setting the bar to aggregate and score the overall risk that an Organisation is not compliant with the essential standards of safety and quality.

Using this framework we judge the overall level of concern that the provider is not fully complaint with the essential standards as **major.**

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

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.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

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

Outcome 1:
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

There are moderate concerns with outcome 1: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us

People who use the service told us that they were involved in decisions which affected them which included meal choices, activities and holidays.

They told us they had a monthly meeting where decisions relating to the home were discussed and agreed. One person told us they were involved in committee meetings where issues relating to the whole organisation were discussed. They told us how an issue they had raised had been addressed almost immediately.

We saw that people who use the service with limited verbal communication were not given a choice of drink with their lunch. We also noted that none of the people using the service were given a choice of pudding.

People told us that their privacy and dignity was generally respected and that staff call them by their preferred name. Staff did not always knock prior to entering their

bedrooms.

Staff did not refer to people by their name. Instead we heard them call people ‘sweetheart’ and ‘darling’.

We saw that a bathroom door was left ajar whilst a person was having a bath.

We observed that a person’s confidentiality was breached. A member of staff discussed the outcome of a person’s health appointment in front of others in the dining room.

One person told us that they were assisted to get up in the morning at 6.30 am but would prefer to get up at 7am.They told us that they could go to bed at a time convenient to them.

Other evidence

We looked at care plans. There was no evidence that these had been discussed and understood by people who use the service. They made no reference to the support required by individuals in making choices and decisions.

The acting manager had identified that this was an area for improvement. Records showed that they had started to assess people’s capacity to make decisions about their care. The minutes of a staff meeting confirmed that this approach had been discussed. .

Training records showed that eleven out of seventeen staff were trained in equality and diversity issues. This was a one off training course.

We observed that people were not encouraged to be independent. Activities such as cooking, cleaning, laundry were undertaken for them.

The proposed new manager had identified that people using the service did not have their own front door key. This was an area of independence they were keen to develop.

All of the bedrooms were single with a hand wash basin. People used the communal bathrooms and showers.

Our judgement

People’s choices, confidentiality, privacy and dignity were not always promoted and respected.

Overall, therefore we found that there are areas of non compliance with this outcome.

Outcome 2:
Consent to care and treatment

What the outcome says

This is what people who use services should expect.

People who use services:

- Where they are able, give valid consent to the examination, care, treatment and support they receive.
- Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
- Can be confident that their human rights are respected and taken into account.

What we found

Our judgement

There are minor concerns with outcome 2: Consent to care and treatment

Our findings

What people who use the service experienced and told us

People who use the service told us that they are consulted on their care and treatment.

One person told us that they had a care plan. A second person thought they had a care plan but was not sure what that meant.

Other evidence

The care plans we looked at included consent forms for staff to administer medication, for doors to be locked and for staff to enter bedrooms to clean and put laundry away.

We were told that once staff had completed the review of people's capacity to make decisions those forms would be reviewed. We observed that some people were clearly able to understand and make decisions. For others this appeared not to be the case.

We saw examples of best interest decision making protocols where people were unable to make important decisions for themselves.

The provider told us that policies and procedures were in place to help staff understand the Mental Capacity Act and the Deprivation of Liberty Safeguards. Training records confirmed that five out of seventeen staff had already received relevant training, with six others booked on a course later in the year.

Our judgement

There were systems in place for people's consent to be sought However, it was not always clear if the person's capacity to consent had been assessed. While training was available on the Mental Capacity Act and the Deprivation of Liberty safeguards only a limited number of staff had completed this training.

Overall, therefore we found that there are areas of non compliance with this outcome.

Outcome 4:
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 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

People told us that they were well looked after and that they received good care. They told us that the medical care was very good and they could see Doctors, Nurses, Physiotherapists and Occupational therapists on site.

People told us that volunteers had recently become involved with the home to provide friendships for them. They told us they had access to some leisure activities but not as much as they would like.

Other evidence

We looked at three care plans and saw that they addressed people's needs in relation to physical, health, personal and emotional care

The care plans were not dated and did not include people's signatures, to indicate they had been discussed with them. The care plans were reviewed monthly by staff and indicated any changes. We saw that people were not included as part of the review of care plans.

Care plans included detailed guidance on how each person's epilepsy affected them. There was a signed protocol in place for how this was to be managed. These

included when emergency rescue medication was to be administered.

One care plan told us that the person suffered from a mental illness. It did not tell us how the mental illness presented or how staff were to manage the behaviour. The action was to ask the Psychologist to medicate.

Care plans included a range of assessments to address potential risks. However they lacked specific detail and were not always person centred.

The acting manager told us that a computerised care plan system is being introduced across the Organisation. Training had commenced for all levels of staff prior to its introduction.

The home had a part time activities coordinator who was responsible for taking the lead on organising activities. Support staff facilitated the programme when the activities coordinator was not there. There was no programme of activities on display to tell people what was planned.

After lunch staff facilitated a game of snakes and ladders with people who wanted to take part.

Our judgement

People were happy with the care and support they received. Although records did not demonstrate that care was delivered consistently, measures were in place to address these shortfalls.

Overall, therefore we found that Milton House was compliant with this outcome.

Outcome 5:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
- Are supported to have adequate nutrition and hydration.

What we found

Our judgement

There are moderate concerns with outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
People told us that the food was very good and they were given enough to eat and drink.

They told us they were given a choice of two meals each day at lunch time.
At lunchtime, we sat with people in the dining room .We saw that people were provided with a pureed diet. This was presented in an appealing manner. People were provided with specialist equipment to enable them to eat their meals independently.

Meals were not served at the same time. This meant that some people at each table had finished their meal before others had been served. People were not given a drink with their meal but offered a cold and hot drink after they had finished eating.

Staff supported people to eat their meals, but we noted that they did not chat with them whilst doing so. One person had to wait until staff had finished helping others, before they were given the assistance they needed. It was apparent that one staff member did not know the name of the person they were supporting with their meal. Another person only ate a small portion of their meal. Staff did not question this, or offer an alternative.

We noted that there was a supply of fresh fruit in the kitchen. We observed that it was not accessible to people. Neither was it offered to people as an alternative pudding or as a healthy snack during the day.

During the mealtime, there was a steady stream of staff walking from the kitchen through to the dining room. We were told that these staff were about to start their shift, and found it easier to use the kitchen door.

We saw that people who required assistance to mobilise were left sitting at the dining room table after the meal had finished.

Other evidence

Some care plans we looked at contained nutritional needs assessments, with input from a dietician where appropriate.

People were weighed regularly, and care plans made reference to the support required for those on a weight loss or weight gain programme.

The home had a four weekly menu. The menus are agreed with people the week before so that the food shopping can be done. They told us that alternatives can be cooked if someone does not like what is on the menu.

The four weekly menus that we looked at were varied and well balanced.

We could not find records to confirm how people who could not communicate verbally made their choice of food and drink known. During our visit, staff did not use pictures or any other aids to promote food and drink choices.

Staff and people who use the service told us that they were not involved in the shopping or cooking of meals.

Support staff are responsible for preparing and cooking the meals. Staff records confirmed that they had attended food hygiene training, but we noted some gaps in the recording of cooked food temperatures.

The staff member that cooked lunch on the day did not understand the food safety temperature guidelines.

We saw that egg sandwiches and an egg salad was already prepared and stored in the fridge for the evening meal. Staff told us they made the sandwiches at 11.30am.

Our judgement

People did not receive the support they required in a timely manner.

Overall, therefore we found that there are areas of non compliance with this outcome.

Outcome 6:
Cooperating with other providers

What the outcome says

This is what people who use services should expect.

People who use services:

- Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

What we found

Our judgement

The provider is compliant with outcome 6: Cooperating with other providers

Our findings

What people who use the service experienced and told us

One person told us that staff had recently taken them to hospital to have their medication changed.

During our visit another person was supported to attend an appointment with the first line nurse.

Other evidence

Care plans confirmed that people who use the service had access to a wide range of health professionals. Their health and medical needs were reviewed regularly.

The care plans we looked at included a summary sheet which outlined the person's personal details, medication and medical needs. Staff told us that this information would be taken to the hospital if a person using the service required emergency treatment

Our judgement

Staff support people to obtain the health and specialist support they need.

Overall, therefore we found that Milton House was compliant with this outcome.

Outcome 7:
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

There are minor concerns with outcome 7: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us

People told us that they knew who to speak to if they felt they were being badly treated by staff or others.

Other evidence

Staff told us of their duty and responsibility in relation to safeguarding. They were aware of the action to take if there was any suspicion of alleged abuse. We saw in training records that staff have received safeguarding training, with updates in this training overdue for eight staff.

We saw an up to date whistle blowing policy displayed on the notice board in the dining room.

The Provider told us that a safeguarding of vulnerable adult policy is in place and that one of the Assistant Directors take the lead role in safeguarding. This included liaison with the Local Authority safeguarding team.

Care plans detailed the support required by individuals in managing their finances with assessments in place to address any potential risks.

In one person's care plan we saw that staff were given guidance to medicate the

individual rather than manage the situation. Records confirmed that staff had attended challenging behaviour training to support them in managing these specific needs.

The home reported a safeguarding incident and took appropriate action to safeguard people.

Our judgement

Systems were in place to protect people from abuse. However some staff practices, lack of specific guidance on the management of behaviours and lack of updates in safeguarding training could potentially put people at risk of harm or abuse.

Overall, therefore we found that there are areas of non compliance with this outcome.

Outcome 8:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the *Code of Practice for health and adult social care on the prevention and control of infections and related guidance*.

What we found

Our judgement

The provider is compliant with outcome 8: Cleanliness and infection control

Our findings

What people who use the service experienced and told us

People who use the service told us that the home was kept clean and that the domestic staff member was very good.

Other evidence

We were told that a full time domestic staff member works in the home. A daily cleaning schedule was in place and staff spring clean people's bedrooms.

The home was generally clean throughout with no unpleasant odours. We saw that the flooring under the cooker was damaged and there was a build up of dirt in that area.

The home had a laundry room with a washing machine, tumble dryer and a separate sluice area.

Staff were provided with protective clothing. Red bags and clinical waste bins were provided to deal with clinical waste and soiled laundry.

Staff told us that information about hazardous chemicals was made available to them. They were not sure where it was kept. We saw that It was hanging up on the notice board in the kitchen.

We saw that staff receive training in infection control with updates provided every two years.

The Provider told us that they have a copy of the Department of Health code of practice for health and social care on the prevention and control of infections and related guidance. They were reviewing the infection control policy and procedures to ensure they are working in line with the code.

Our judgement
People who use the service are protected by a good standard of hygiene and cleanliness.

Overall, therefore we found that Milton House was compliant with this outcome.

Outcome 9:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are minor concerns with outcome 9: Management of medicines

Our findings

What people who use the service experienced and told us
People told us that staff give them their medication and that they get it at the required time.

Other evidence
We saw that medications were kept securely in a medication trolley in the office. The trolley was taken into the dining area to administer lunchtime medications. Excess stock of medication was kept in a locked cabinet in the office which included a facility for storing controlled medications.

Care plans included a medication consent form for staff to administer people's medications. This was not signed by them. The acting manager had already identified that this form was unsuitable and was not to be used. We saw in the team meeting minutes that discussions had taken place on this.
People's care plans included an incomplete medication assessment form. This told us that the person required staff to administer their medication. As the assessment document was incomplete it was not clear how they had come to this conclusion. None of the people using the service were being supported to manage their own medication.
We saw that staff involved in medication administration were trained and deemed

competent to administer medication.
The medication administration records we looked at had been fully completed.
The medication administration records contained a photograph of the individual and gave information about any allergies. These records had been written and signed by the prescribing doctor.
We saw that one person was prescribed two different “as required” medications for agitation. There was no guidance as to how this agitation presented and no protocol to help staff decide which medication should be given.

During the visit we saw staff administer medication appropriately. However two people were given their medication on a spoon. Staff told us this was required for those individuals. One person’s care plan told us this was how their medication was to be administered. The other person’s care plan did not tell us that they required any support to take their medication.

All medication errors were reported internally on a mismanagement of medication form. They told us that medical advice was sought. We saw from the mismanagement of medication reports that one staff member was responsible for a number of medication errors. This had not been addressed with the staff member concerned.

We saw that a daily check of medication administration records and a count of medications took place. This addressed errors in a timely manner.
The Provider told us that a medication policy was in place, which is currently under review. The acting manager told us that the on site pharmacist carry out yearly audits of each of the services. The last audit for Milton house took place in January 2010 and one was scheduled for 2011

Our judgement
People may not have their medications safely and as prescribed. This is because patterns of staff errors in medication administration are not addressed and guidance is not provided on the administration of as required medications.

Overall, therefore we found that there are areas of non compliance with this outcome.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:

- Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

There are minor concerns with outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us

People told us that they liked living at the home, that it was kept clean and well maintained. We saw that bedrooms were personalised.

Other evidence

Milton house accommodates 12 people. All of the accommodation is on the ground floor.

All of the bedrooms were single with a sink. There were three shower rooms and two bathrooms with toilets and two other toilets.
There was a large kitchen and a dining room with a smaller sitting area.
There was another small quiet room sitting area which had all of the armchairs lined up in a row and the overhead hoist went along in a row. No person used this room during the review.
The corridors were wide and wheelchair accessible and the home was clean and bright.

Care plans included personal emergency evacuation plans. Staff had received fire safety training, with updates in this training overdue for nine staff. A fire based risk assessment was in place and fire safety equipment was provided and serviced.
We saw that a store cupboard and cupboard under the kitchen sink containing supplies such as latex gloves and cleaning materials was left unlocked and

insecure. There were no risk assessments in place to support this practice.

Our judgement
The overall design and layout of Milton house is suitable for the people who use the service.

Staff practice in relation to leaving the store cupboard insecure and lack of updates in fire training poses risks to the safety and well being of people who use the service.

Overall, therefore we found that there are areas of non compliance with this outcome.

Outcome 11:
Safety, availability and suitability of equipment

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:

- Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
- Benefit from equipment that is comfortable and meets their needs.

What we found

Our judgement

The provider is compliant with outcome 11: Safety, availability and suitability of equipment

Our findings

What people who use the service experienced and told us

We saw people using specialist equipment such as crockery, cutlery, wheelchairs and walking frames to promote their independence.

We saw that people were provided with specialist chairs and beds to provide comfort for them and maintain their safety

Other evidence

We saw in care plans that people who use the service were assessed and specialist equipment provided where required to promote independence and safety.
We saw that moving and handling risk assessments were completed. Records confirmed that staff were trained in moving and handling techniques.

The home had adapted baths, showers with chairs, portable and overhead hoists. Handrails were provided around the home. Records showed that equipment was due to be serviced.
We saw a first aid box in the kitchen and we saw that a percentage of staff received first aid training. We were told that a registered nurse was available on site 24 hours a day to deal with medical emergencies.

We were told that the health and safety officer had carried out a recent health and safety audit of the home. An action plan was in place to address issues highlighted.

The Provider told us that medical device alerts were managed centrally and reported to the home. Health and safety policies and procedures were in place to support staff practice.

Our judgement
People were provided with suitable equipment. There were systems in place to make sure that this was safely maintained.

Overall, therefore we found that Milton House was compliant with this outcome.

Outcome 12:
Requirements relating to workers

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 staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

The provider is compliant with outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us

People told us that they were not involved in interviewing staff.

Other evidence

We saw in two staff recruitment files that a range of pre employment checks had been carried before staff started work at the service. The files each contained a job description together with completed application form, proof of identity, two references and a Criminal Record Bureau check.

We saw that staff promoted internally had to complete a new application form and attend for an interview to assess competencies for the post.

We saw that bank or agency staff were used to cover shortfalls in the rota. Confirmation of recruitment checks and training for those staff are accessed on the computer. We saw on the computer that a sample of those staff had the required pre employment checks in place.

Our judgement

People who use the service could be assured that there were robust staff recruitment procedures in place.

Overall, therefore we found that Milton House was compliant with this outcome.

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

There are minor concerns with outcome 13: Staffing

Our findings

What people who use the service experienced and told us

People told us that they thought the home could do with more staff at certain times of the day and should employ more men. .

We saw that there were not sufficient staff available at lunchtime to serve and assist people with their meals in a timely manner.

People told us that they were anxious about recent staff changes. The registered manager had left and a new manager was due to start at the home. They told us this individual had been visiting the home and getting to know them

Other evidence

The acting manager told us that they had three full time support worker vacancies and one part time catering assistant vacancy. The catering assistant post is new to the establishment.

There was a senior member of staff on duty at all times to ensure that the service was appropriately managed.

During our visit, there was a domestic assistant and five support staff on duty, three of whom were bank workers.

At the time of this review the home was being managed by one of the acting directors in an acting manager's role. She had been in post since December 2010 and had commenced a programme of improvements.

A registered manager from another location that is closing was due to take over management of the home from March 2011. She had been working closely with the acting manager and getting to know the people who live there.

Our judgement

Shifts were not managed to ensure that sufficient staff were available to support people who use the service at peak times of the day.

Overall, therefore we found that there are areas of non compliance with this outcome

Outcome 14:
Supporting workers

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 competent staff.

What we found

Our judgement

There are minor concerns with outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us

People told us that they thought the regular staff were well trained. They also said that staff that came in at short notice were not and did not know what to do.

We saw that an agency staff member was brought into the dining area and told to sit at the table to keep an eye on one individual. They were not introduced and people told us that they did not know who they were.

Other evidence

Records confirmed that all staff had attended a five day corporate induction. The induction programme was comprehensive. It included training in the principles of care, epilepsy awareness, moving and handling theory, health and safety, equality and diversity, introduction to challenging behaviours, basic life support, basic food hygiene, safeguarding of vulnerable adults, fire awareness and communication.

Following this new staff had completed an in house induction getting to know people who use the service.

One of the bank workers on duty told us that they had a quick induction into the home and was shown the fire exits. They confirmed they were told the names of people that use the service but could not remember them. This included the person

that they were assisting with their meal.

We looked at a sample of training records. We noted that a number of staff were overdue for updates in mandatory training such as fire safety, food handling, first aid and safeguarding. They were provided with specialist training such as challenging behaviours and epilepsy awareness training but the frequency of this varied. We were told that thirteen staff had completed a National Vocational Qualification in care at level 2 or above.

Some of the staff practice we observed indicated that skills and knowledge covered in training was not being put into practice. We saw that the organisation's policies and procedures were not always followed.
Staff told us that they receive regular formal supervision from their line manager. The acting manager told us that she monitors this. Records showed that regular staff meetings took place. Staff told us that they felt suitably trained and supported in their roles.

Our judgement

People may not always be safe with their health and welfare needs met by competent staff. This is because although staff receive induction, training and supervision not all training is current. Neither do staff consistently apply what they have learnt.

Overall, therefore we found that there are areas of non compliance with this outcome.

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

People told us that monthly house meetings took place which allowed them to raise issues that concerned them.

We saw records of those meetings which showed that people who use the service were consulted on the quality of care.

People told us that volunteers had recently become involved with the home which provided support to them.

Other evidence

We saw from reports that the provider carries out monitoring visits. The last report on file was dated August 2010.

The acting manager told us that a new quality monitoring system is due to be introduced which will relate to the 16 essential outcome areas.
We saw that internal audits took place. These included financial, medication, health and safety audits as well as reporting on complaints, seizures, safeguarding referrals, medication errors and accident /incidents.

The Provider told us that generic risk assessments were in place.
Risk assessments relating to people who use the service were contained in care plans.

Our judgement

Milton house had procedures in place for monitoring the quality of care experienced by people who use the service.

Overall, therefore we found that Milton House was compliant with this outcome.

Outcome 17: Complaints

What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:

- Are sure that their comments and complaints are listened to and acted on effectively.
- Know that they will not be discriminated against for making a complaint.

What we found

Our judgement

The provider is compliant with outcome 17: Complaints

Our findings

What people who use the service experienced and told us

People told us that they knew who to talk to if they were unhappy with their care.

They told us that they felt they could also raise issues at the house meeting and that issues raised are addressed.

We saw a complaints procedure displayed in communal areas of the home. This did not include up to date contact details of the Commission.

Other evidence

The acting manager told us that no complaints had been received. She told us she is in the process of reviewing with people who use the service whether they would like a “grumble book”, put in place to enable them to bring to staff’s attention issues that they may be unhappy with.

The Provider told us that complaints are reported centrally with an audit of complaints carried out which feeds into the organisation’s annual report

Our judgement

Milton House had systems in place to enable people who use the service to raise complaints.

Overall, therefore we found that Milton House was compliant with this outcome.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:

- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

The provider is compliant with outcome 21: Records

Our findings

What people who use the service experienced and told us
We did not get any feedback from people using the service in this outcome area

Other evidence
We saw that records were kept up to date, stored safely and securely. The acting manager was in the process of reorganising files and improving filing systems.

The Provider told us that they have reviewed and updated their policy on retention and disposal of records to make sure that they meet legal requirements.

Our judgement
Milton house had systems in place to manage records to safeguard and protect people who use the service.

Overall, therefore we found that Milton House was compliant with this outcome.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	**18**	2
	Why we have concerns: There was systems in place for people's consent to be sought. However, it was not always clear if the person's capacity to consent had been assessed. While training was available on the Mental Capacity Act and the Deprivation of Liberty safeguards only a limited number of staff had completed this training.	
Accommodation for persons who require nursing or personal care	**11**	7
	Why we have concerns: Systems were in place to protect people from abuse. However some staff practices, lack of specific guidance on the management of behaviours and lack of updates in safeguarding training could potentially put people at risk of harm or abuse.	
Accommodation for persons who require nursing or personal care	**13**	9
	Why we have concerns: People may not have their medications safely and as prescribed. This is because patterns of staff errors in medication administration are not addressed and guidance is not provided on the administration of as required medications.	
Accommodation for persons	**15**	10

who require nursing or personal care	**Why we have concerns:** The overall design and layout of Milton house is suitable for the people who use the service. Staff practice in relation to leaving the store cupboard insecure and lack of updates in fire training poses risks to the safety and well being of people who use the service	
Accommodation for persons who require nursing or personal care	**22**	13
	Why we have concerns: Shifts were not managed to ensure that sufficient staff were available to support people who use the service at peak times of the day.	
Accommodation for persons who require nursing or personal care	**23**	14
	Why we have concerns: People may not always be safe with their health and welfare needs met by competent staff. This is because although staff receive induction, training and supervision not all training is current. Neither do staff consistently apply what they have learnt.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent within 28 days of this report being received.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	**17**	1
	How the regulation is not being met: People's choices, confidentiality, privacy and dignity were not always promoted and respected.	
Accommodation for persons who require nursing or personal care	**14**	5
	How the regulation is not being met: People did not receive the support they required in a timely manner.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

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.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, 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 Adult 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

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
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