Follow up report

The National Society for Epilepsy Milton House	
Region:	South East
Location address:	The National Society for Epilepsy Chesham Lane, Chalfont St Peter Gerrards Cross Buckinghamshire SL9 0RJ
Type of service:	Care home service without nursing
Date of Publication:	January 2012
Overview of the service:	Milton House is a care home without nursing. It is registered to provide accommodation for people who require nursing or personal care. It accommodates 12 people with a learning disability.

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

Our current overall judgement

Milton House was meeting all the essential standards of quality and safety.

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

Why we carried out this follow up

We carried out this follow up to check whether Milton House had made improvements in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 05 - Meeting nutritional needs

How we carried out this follow up

We reviewed all the information we hold about this provider and checked the provider's records.

What people told us

We did not speak with people for this review.

What we found about the standards we followed up

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 choices, confidentiality, privacy and dignity was promoted and respected.

The registered manager told us and provided evidence that people's care plans had been updated to reflect how they made choices and contribute to the decision making process. We saw from the information provided that people who use the service were involved in the interview process and people had been informed of the organisations philosophy of care and rights.
We saw that staff had been trained in best practice and individual staff questionnaires had been completed on how to promote dignity.We were informed that issues from those questionnaires were addressed with individual staff. The manager advised us that staff practice was being observed and issues of poor practice were being addressed with individual staff in supervision.
We were provided with a copy of the staff handbook. We were told that all staff had been given a copy. We saw that the handbook provided guidance on best practice. We saw

records of team meetings which reinforced staff roles. It also reminded staff of the expectations that they would promote, respect and involve people who use the service in their care.

Outcome 05: Food and drink should meet people's individual dietary needs

Staffing had been rearranged to ensure that sufficient staff were available to support people with their meals in a timely manner.

The registered manager told us that the rota had been rearranged to ensure that there were sufficient staff on duty at mealtimes to provide the right support for people.
We saw from copies of menus that people were offered choices in relation to meals. We were told that care plans had been updated to reflect the level of support required by people at mealtimes to ensure that all staff were consistent in the care provided.

Other information

Please see previous review reports for more information. We will follow these up separately.

What is a follow-up report?

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.

CQC licenses services if they meet essential standards and we 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.

When we have completed a review of compliance, we publish a report on our website as soon as possible setting out our findings and judgements.

If we asked the provider to send us a report saying what they were going to do to either maintain or meet the standards, we follow this up to make sure that the necessary improvements have been made.

We publish a follow-up report when improvements have been made.

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 generally do one of three things:

- Set **improvement actions:** These are actions a provider should take so that they **maintain** continuous compliance with essential standards.

- Set **compliance actions:** These are actions a provider must take so that they **achieve** compliance with the essential standards.

- Take **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.

Care Quality Commission

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