Four Seasons Homes (Ilkeston) Limited

Nottingham Neurodisability Service Hucknall - Millwood

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

Nottingham Neurodisability service Millwood is part of Huntercombe Services Nottingham. It is a rehabilitation unit for adults with acquired brain injury and other complex neurological conditions. The registration is made up of three individual houses adjoining each other, Millwood, Fernwood and Rosewood. Together they can provide care for up to 71 people. At the time of our inspection there were 69 people living at the home. We inspected the service on 20 January and 21 January 2016

The home had a registered manager who was on duty on both days of the 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.

Summary of findings

Each of the three houses that made up the registration was managed by a unit manager. The registered manager oversaw the management of each house and the service as a whole.

People who used the service, and their representatives, felt safe and well supported. Staff were confident that people's needs could be met safely and effectively. Detailed risk assessments were in place to support safe practice.

Staff had a good understanding of what constituted abuse and would be confident to recognise and report it. Senior staff, including the registered manager, were aware of their roles in relation to reporting allegations to appropriate external agencies and working with them to ensure incidents were investigated.

There were sufficient staff employed to meet people's needs effectively and staff were recruited through safe recruitment practices. Medicines were stored and administered safely and the premises were well maintained to keep people safe.

Staff received appropriate induction, training and supervision. Staff were very positive about the support and training they received. Training was relevant to staff roles and some training was geared specifically around people's individual health and support needs. Staff understood their roles and responsibilities and worked well together as a team to deliver good quality care.

People's rights were protected under the Mental Capacity Act 2005 and decisions were regularly reviewed when individual's needs and circumstances changed to ensure they still reflected their wishes.

People were provided with sufficient food and drink to maintain their good health and wellbeing, and the standard of food provided was very good.

People told us that staff were kind and caring. Staff enjoyed their work and found it very rewarding. They were very knowledgeable about people's needs, preferences and life experiences. Staff respected people's privacy and dignity.

People received personalised care that was responsive to people's individual needs. The service worked with a range of specialist workers to provide rehabilitation. These specialists worked alongside support staff to meet assessed needs. Staff worked with outside agencies appropriately. Although not all care plans were up to date staff understood peoples support and care needs.

People enjoyed a range of 'therapies' and activities. Programmes were developed around individual needs and were more structured for people undergoing rehabilitation programmes. Activities were not as regular for people living at the home long term.

People and their relatives (where appropriate) were involved in the development of the service. People felt listened to and would be confident to make a complaint or raise a concern if they needed to. Staff were aware of the complaints procedure and outside agencies supported people with decision making when appropriate. People living at the home and the staff team had opportunities to be involved in discussions about the running of the home and felt the management team provided good leadership. There were systems in place to monitor the quality of the service provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

The provider had systems in place to recognise and respond to allegations or incidents of abuse and these were used effectively.

People received their medicines as prescribed and medicines were managed safely.

Staffing levels were sufficient to meet people's needs and offered flexible support.

Recruitment procedures were good ensuring that only people suitable to work with vulnerable people were appointed.

Good

Is the service effective?
The service was effective.

Staff received appropriate induction, training and supervision.

People's rights were protected under the Mental Capacity Act 2005.

People received sufficient to eat and drink.

In house and community based health and social care professionals were involved in people's care as appropriate.

Good

Is the service caring?
The service was caring.

Staff were kind, caring and respectful when supporting people to meet their care and support needs.

People's privacy and dignity was respected and promoted.

People were listened to and were supported to be able to make decisions and choices.

Good

Is the service responsive?
The service was responsive.

Care records provided clear guidance for staff to respond to people's needs.

People enjoyed a range of activities.

A complaints procedure was in place and staff knew how to respond to complaints

Good

Is the service well-led?
The service was well-led.

Staff had opportunities to review and discuss their practice regularly.

The management team were approachable and sought the views of people who used the service, their relatives and staff.

There were procedures in place to monitor and review the quality of the service.

Good

Nottingham Neurodisability Service Hucknall - Millwood

Detailed findings

Background to this inspection

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

This inspection took place on 20 January and 21 January 2016 and was unannounced.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the PIR and other information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection we spoke with four people who used the service about the care and support they received. We spoke with five people's representatives (friends and relatives), the registered manager, the deputy manager and ten staff working in different roles within the service.

We looked at four care records, three staff recruitment files and other records relevant to the running of the service. This included policies and procedures and information about staff training. We also looked at the provider's quality assurance systems.

Good

Is the service safe?

Our findings

Due to the complex needs of some of the people who used the service we were only able to speak in depth with four people. They all told us that they felt safe. One person said, “They [staff] keep me warm and safe.” Another person said, “There is no bullying or discrimination.” People’s representatives also considered people to be safe and staff were confident that they provided safe care and support.

Staff told us that they had received training to protect people from abuse. They were able to demonstrate a good knowledge of how to recognise and respond to allegations or incidents of abuse. They understood the different types of abuse and knew the signs to watch for to indicate it was happening. Staff also understood the process for reporting concerns. The registered manager told us how they had made referrals and worked with social care professionals to keep people safe. We had received reports from the provider that reflected this.

When staff had noticed injuries or marks on people they recorded it. We saw that body maps had been completed to record any injuries and/or skin and where possible there was an indication of how they had occurred.

Risks had been assessed and plans implemented to reduce them as far as possible. There was a risk assessment for one person who was unable to communicate to identify and mitigate the risk of abuse from others. Interventions to reduce the risk had been identified to protect that person.

Procedures were in place to protect people in the event of an emergency, such as a fire. We saw how regular checks and routine maintenance of the home environment and equipment ensured people could be kept safe. We saw records that demonstrated this and staff told us of procedures to follow to raise issues that required attention. Audits reflected that staff regularly checked the home to ensure it remained safe and appropriate. Repairs and maintenance were carried out promptly. Overall the premises were clean however equipment in two of the kitchen areas, notably the microwaves and the cookers, were not reflective of the standards seen throughout the rest of the home.

Each of the care records we looked at contained a range of individual risk assessments to assess risks such as nutrition, choking, pressure ulcers, and falls. These had been reviewed monthly and actions identified to reduce these risks. We saw pressure relieving mattresses and other equipment to reduce the risk of pressure ulcers were in place where people were at risk of developing pressure ulcers. When bed rails were used risk assessments had been completed and it was documented that relatives had been involved in the decision making process when appropriate. Moving and handling assessments had been completed and we saw for one person, who needed very specific positioning and support, there was a diagram showing the seating position and the position of support devices.

Staff told us they had sufficient equipment available to meet the needs of people who used the service. When specialist equipment was needed, it was provided. However, we found one person had been waiting for an extended period for a splint. When we talked with staff they explained that other actions were being taken to ensure the absence of the device did not have a detrimental effect on the person’s progress or well-being.

On the day of the inspection there appeared to be adequate staff on duty to meet the needs of the people who used the service. People told us that their requests for support were met in a timely manner. A relative told us that staff were busy but always communicated any delays to reduce anxiety and that this was acceptable to them. Staff told us that they considered there were enough staff available to meet people’s needs. One staff member told us, “There are enough staff. It’s much better now. Staffing downstairs has increased as a direct result of staff saying that more were needed.” The registered manager told us that they used a dependency tool to assess staffing levels and that levels were constantly reviewed as people were admitted and discharged.

We looked at the recruitment files of three staff who had recently started working at the home. We saw that required information was available to demonstrate a safe recruitment process. People were supported by staff who had been properly vetted to check they had the right attributes to care for people and ensure their safety. Files seen did not contain pictures of staff although proof of ID documentation did provide pictorial evidence of who a person was. The registered manager and the Human Resources lead were fully aware of their role in relation to following safe recruitment practices.

People were protected against the risks associated with medicines because the provider had appropriate

Good

Is the service safe?

arrangements in place to manage them safely. Medicines were stored in locked rooms and locked trolleys. However the refrigerators used to store medicines on the ground floor and first floor of the Millwood unit were not kept locked (although they were situated within a locked room). Temperature checks of the rooms and refrigerators were recorded daily and were within acceptable limits. Liquid medicines and topical creams were labelled with their date of opening. We checked two controlled medicines and found the number corresponded with the number recorded in the controlled medicines record book. We saw weekly checks had been recorded of all controlled medicines.

We observed some medicines being administered at lunchtime. We saw staff made the required checks against the medicines administration record and stayed with the person until they had taken their medicines. We saw two staff checked and administered controlled medicines and documented this in requirements. Medicines administration records (MAR) had a photograph of the person at the front and a record of any allergies. Some, but not all, gave information about how the person liked to take their medicines The information was also recorded in the care plans. When medicines had to be handwritten on the MAR, there were two signatures to indicate they had been checked by a second person for accuracy of transcription. We saw some inconsistencies in some recording of some medicines. In particular medicines taken as and when required and the application of transdermal patches. We discussed this with the nurse on duty.

The nurse on duty had good knowledge of managing and administering medicines, this included medicines given directly into a person's stomach. Documentation demonstrated equipment used to administer this medicine was changed in line with best practice to ensure their ongoing safe use.

Good

Is the service effective?

Our findings

People told us that staff supported them effectively and met their needs well. One staff member told us, "People are well looked after here. We provide good care."

Staff felt well trained to carry out their roles effectively. One staff member told us, "I think the training is very good." Another staff member told us, "There is a lot of training going on." Staff told us that there were excellent opportunities to access training which was specific to the individual needs of the people they supported. A senior staff member who delivered training in house told us how they were able to tailor training around individuals and as a result make it more effective. Staff told us they had the opportunity to attend additional training appropriate to their role. They said there were monthly seminars on topics relevant to the people who used the service to enable staff to extend their knowledge.

We saw records reflecting that staff training was available to cover a range of topics including health and safety and moving and handling. We saw that completion rates were not accurately reflected to give us a true reflection of training completed. This had been identified by the registered manager and their senior team. Actions had been taken to improve this and were on going. They told us that a new recording system would reflect more accurately actual training provided. Guidance was available to staff on best practice in relation to clinical procedures being undertaken, and people's care records contained information on the specific requirements for each person.

Staff felt well supported by each other, senior staff members, and by the deputy and the registered manager. Staff said that that communication at all levels was 'excellent'. Staff told us that they had regular opportunities to meet with their unit managers and formally discuss their personal and professional development. Staff told us that they worked effectively as a team. One staff member told us, "We have a strong team. There is always support available."

New staff were supported to gain the skills and knowledge needed for their roles they were appointed for. The provider had an induction programme for new staff that included the Skills for Care Certificate. The certificate has been developed by a recognised workforce development body for adult social care in England. The certificate is a set of standards that health and social care workers are expected to adhere to in their daily working life.

Staff told us how they supported new staff. We talked with a member of staff who had commenced working at the service within the last three months and this was their first post within a care setting. They told us they had had a comprehensive induction including two weeks of shadowing, the first with care staff and the second with another person in a similar role to themselves. They had also completed mandatory training. They had spent some time in the different units and had been supervised until they felt ready to undertake their role independently. We spoke with an agency staff member. They told us that they had worked at the home on previous occasions and were confident they had the information needed to offer effective care and support. They told us that staff members were on hand to offer support and guidance and they were not afraid to ask.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People were fully involved in decision making processes. Staff respected people's decisions and encouraged them to remain in control of how they lived their lives.

Consent to care and treatment was sought in line with legislation and guidance. For example, we saw that consent had been obtained for the use of photographs in the care record.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and they were.

When people were unable to make some decisions about their care and treatment themselves, mental capacity assessments had been undertaken. There was evidence of

Good

Is the service effective?

the involvement of the person's relatives and where appropriate other members of the multi-disciplinary team in the best interest decision making process. For example, when a lap belt was required to maintain a person's position in their chair a mental capacity assessment had been undertaken and the person's close relative had signed to indicate they consented to the lap belt being used.

Most people were under the supervision of staff for up to 24 hours a day and were unable to leave the unit. DoLS applications had been made in line with requirements and the care records we reviewed contained evidence that either authorisation had been given or the application had been submitted and the outcome was awaited. Staff were knowledgeable about deprivations and safeguards. They understood their roles and responsibilities in relation to adhering to them and had received training to support them in that role.

We reviewed the care of a person who displayed behaviour that challenged and saw there were clear instructions for staff on de-escalation techniques to manage the behaviour and a mental capacity assessment and best interest decision in relation to this. This meant staff could offer safe and consistent support.

Everyone we spoke with told us that they enjoyed the food. One person told us, "The food is usually good here." A relative told us how they were often asked if they would like to share a meal at the home and it was always of good quality.

Staff were aware of people's dietary needs. Care records were very detailed about people's nutritional needs and any restrictions due to their medical conditions. Meals were prepared taking individual needs into account and support from dieticians was sought when required and guidance followed. For example, some people were receiving enteral nutrition and when this was the case, a feeding plan had been initiated by a dietician. We saw this was being provided in line with the guidance. Enteral nutrition refers to food being given directly into a person's stomach.

Care records detailed people's likes and dislikes in relation to food and also any allergies. People told us that there was always a choice offered. On the day of the inspection there was a choice of two hot meals. A five week menu was in place and records of what people had chosen each day reflected individual choices.

We observed part of the lunchtime meal in all three houses. We saw people were assisted with their meal when they were unable to eat independently and staff were attentive to everyone's needs.

People had access to an on-site multi-disciplinary team of professionals including a clinical psychologist, physiotherapists, speech and language therapists, occupational therapists and rehabilitation assistants in addition to nurses and support workers. We saw there was holistic approach to the care of people with excellent multi-disciplinary team working. There was also evidence of the input of hospital services and other external services such as a tissue viability nurse, or dietician where appropriate. Staff were knowledgeable about people's health needs and worked closely as a team to ensure care was assessed, reviewed and delivered appropriately. We saw detailed notes documenting aims and goals in relation to rehabilitation, including progress made.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring. A relative told us, "Staff are all so kind and caring." We saw that people who used the service were relaxed with staff and staff had a good knowledge of people's needs and preferences. We saw staff offer reassurance and support to people when they became anxious or confused. Staff were clearly committed to the people they cared for and made great efforts to ensure they had explored all options for their well-being. Staff spoke with compassion and sensitivity. They told us how they offered physical and emotional support to family members and people who used the service. One staff member said, "We all care. Any one of us could be in their situation. We listen and we care." A relative told us, "They are as kind to me as they are to [my relative]."

Staff were able to tell us about people's individual needs and preferences. One staff member told us, "We get to know people well." Staff were positive about people fulfilling their goals and objectives. Staff were proud to share people's individual achievements and said that their jobs were rewarding and satisfying as a result.

People were involved in making decisions about their lives. We saw how people were consulted about all aspects of their care and support. They were involved in setting goals and objectives and were present when they were reviewed. When people were unable to contribute, relatives were involved as appropriate.

People's representatives told us that they were welcomed at the home and encouraged to visit whenever they wanted. One relative told us that they were very involved in supporting their family member and were able to carry out a number of personal care tasks. They told us how they both gained comfort from this. Staff knew this was important to the person who used the service and the relative and enabled it to happen. We saw evidence of the involvement of close relatives in multi-disciplinary meetings and a relative told us they were able to speak with each of the members of the multi-disciplinary team whenever they asked.

Staff knew how people communicated their care and support needs. They told us how they recognised people's changing moods. We saw staff offering sensitive support to a person who had become distressed. They used touch appropriately and spoke with the person on their level enabling eye contact. Their intervention gave the person reassurance and they started to relax.

People's social and emotional needs were considered and met. There were staff available to sit with people and discuss the emotions they were feeling. Relatives told us that this was reassuring and had a positive effect on the progress of the person being supported. Staff told us how they listened to people and acted in accordance with their wishes. They told us that they offered flexible support to respond to how a person was feeling. For example, one person did not feel like having their bath until later in the day and staff were able to accommodate their changing wishes. One person told us that they were able to 'open up' to staff offering them reassurance and comfort. They said that the staff member related well to them and as a result they felt relaxed and comfortable to share their feelings.

Staff told us that they promoted people's independence and offered guidance when appropriate. People told us that staff responded when they asked for support and that their independence was promoted.

We observed people being treated with dignity and respect. Staff spoke discreetly with people when they needed to check on sensitive or private issues. Staff were supportive and respectful at all times. In conversations they told us how they respected people's privacy and dignity. One staff member told us, "The dignity team promote wellbeing and independence. They are currently looking at increasing meaningful activities. We are all getting involved."

A person who used the service told us, "My privacy is always respected. Everything I need doing happens in my room. I like it that way." We saw that when staff entered people's bedrooms they knocked and waited to be invited in. People's representatives told us that they had also seen this.

Good

Is the service responsive?

Our findings

The service was responsive to people's individual needs and wishes. Everyone who we spoke with told us how staff provided the care and support that they needed. Care was personalised and people were consulted and involved as far as they were able in developing care and support plans. People's representatives told us that they were also involved when appropriate.

Staff had the knowledge and skills to meet people's needs consistently and appropriately. They told us that communication was the key to offering responsive support that was focussed around people's individual needs. Communication between support staff and therapy staff was good. Staff told us they worked well together and this was essential to people's rehabilitation.

Individual needs and preferences were recorded and information was shared with staff to ensure everyone involved in delivering a person's care had the information required. Care plans were regularly reviewed to ensure that they remained current and we saw that when people's needs changed plans were updated to reflect this.

Staff were provided with detailed information about the people they supported. Each care record contained a full pre-admission and admission assessment with details of the person's history and care and support needs. There was a life story and also information about people's interests and how to communicate with them. Each person had a full range of care plans to identify their care and treatment requirements. These had been reviewed monthly and contained a good level of detail regarding the person's needs and preferences. However, we found a small number of instances where the care plans had not been updated in response to recent changes to the person's care. For example one person's care plan indicated they wore an arm splint for two hours in the morning and in the afternoon. However, we were told these had been discontinued and other interventions instigated. All the staff we talked with were aware of this and it did not have an impact on the person.

Most people who used the service were there undergoing a period of rehabilitation. Short and long term goals and objectives were set and then all members of the care and support team worked with the person to achieve them. Most goals centred around developing independence. Staff told us that progress towards meeting goals varied depending on the person. They were confident that they could meet people's needs. In house therapy services enabled people to develop new skills and also re learn skills that they had lost. Progress was recorded and regularly reviewed. Staff told us that a number of people who received a service moved on to more independent living and this gave them a sense of achievement.

Staff worked with outside agencies to ensure a smooth transition to a more independent life. Staff told us how effective communication and sharing of information between teams led to a person's 'move on' being more successful. One staff member told us how they were working on how this could be best achieved.

People who were undergoing a rehabilitation programme had a timetable of activities and we observed one to one sessions and group activities. For example one person was colouring pictures with encouragement and support on a one to one basis and later a large group of people were baking in the kitchen, some of whom had individual support.

There were fewer planned activities for people who were not undertaking an active rehabilitation programme. We observed one person who spent the morning in the lounge with the television and would not have been able to join in the group activity. They were also in the lounge during the afternoon. We talked with one of the activities coordinators and were told they had a good range of equipment and materials available for activities. Activities ranged from board games, a film group, craft sessions, a reading group, creative writing group and social activities and outings. A newsletter was produced by the occupational therapists with contributions from the activities coordinators and contained photographs, poems written by people, film reviews as well as news about the unit. There was an activities coordinator for each unit who worked Monday to Thursday and one coordinator covered all three units from Friday to Sunday.

We saw that the service had a complaints procedure however the one displayed was not in an easy to read format and was dated 2010 suggesting it had not been reviewed or updated to reflect current information. Following our inspection the registered manager sent us information about complaints and their resolutions. We saw that in 2015 there had been three complaints, all of which had been investigated appropriately and resolved.

Good

Is the service responsive?

A relative who spoke with us said that they would always aim to resolve complaints informally. They said that they would speak with any staff member to share worries or concerns. They told us how they had raised an issue recently and it had been resolved quickly and sensitively. They said that they had not been treated any differently as a result and was happy with the prompt response and resolution. Staff told us that they were aware of the complaints procedure and it was shared with people who used the service.

Good

Is the service well-led?

Our findings

All of the people we spoke with thought the service was well run. One person told us that the unit managers were approachable and visible. They knew who the registered manager was although said that they saw them less often. The registered manager told us that unit managers were first point of contact for people but they had an open door policy should anyone wish to speak with them directly. There was an organisational structure on the wall clearly identifying who's who within the service.

The registered manager told us that they felt well supported in their role and were aware of their individual roles and responsibilities. They worked with senior managers to monitor and review the service provided. They had the skills to provide effective leadership within the home. We saw how managers within the organisation met regularly to evaluate the services provided and in house clinical governance meetings regularly took place to review audits and quality assurance outcomes. We saw minutes of these meetings which included action plans.

Staff told us that they would be confident to raise any issues, concerns or suggestions. Staff knew about the whistle blowing policy and said they would use it if necessary. The whistle blowing policy enabled staff to feel that they could share concerns without fear of reprisal. Staff told us how they shared information between staff teams and with outside agencies to ensure continuity of care. Staff told us that meetings regularly took place to enable staff to meet as a whole team and discuss the service provided. They told us they took turns in chairing the meetings. The agenda was distributed in advance and everyone was encouraged to contribute to the agenda. We looked at the meeting records. They reflected that discussions took place about the standards of care expected and plans of how they could meet people's needs and wishes.

Staff told us said that their unit managers were very approachable and their doors were always open. They told us they felt they would be listened to and that the registered manager would also act to address any concerns or issues they raised. One staff member said "I feel it is very transparent here."

There were systems in place to monitor the quality of the service provided. The registered manager told us that the provider regularly reviewed the service and the management of the home. They completed audits and produced action plans to demonstrate targets were met. Staff were aware of the service's policies and procedures and the registered manager told us that they were adhered to. We saw there was a list of monthly audits on the wall and who was allocated to undertake them.

The service was implementing an electronic care record system and at the time of the inspection some of each person's care record was in paper format and some was on the computer system. This meant there was some fragmentation and staff were not always clear where specific information was stored. There was also the possibility of duplication. There appeared to be reasonable access for staff to the computerised record. Paper records were not up to date and the registered manager said that housekeeping was an area where improvement was required. The new system would resolve this issue.

The registered manager made sure that the environment was appropriate and well maintained. Monthly manager reports checked that areas were regularly audited. For example, a recent report identified that an infection control audit had taken place and an action plan had been implemented. This report informed the registered manager how well staff were carrying out the tasks delegated to them

Accidents and incidents were monitored for trends and care plans were updated in light of these. The registered manager had reviewed information to see what lessons could be learnt from them.

Registered persons are required to notify CQC of certain changes, events or incidents at the service. Records showed that we had been notified appropriately when necessary. A notification is information about important events which the provider is required to send us by law.