Governors of Sutton's Hospital in Charterhouse

Queen Elizabeth II Infirmary

Inspection report

Master's Lodge
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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

Summary of findings

Overall summary

The Queen Elizabeth II infirmary provides residential care to a maximum of 11 people. Accommodation is provided in single rooms, with shared living and dining facilities. The service currently has nine people in residence.

This inspection took place on 9 and 15 November 2018 and was unannounced. At our previous inspection on 20 April 2016 the service was meeting all the regulations that we reviewed and was rated as good.

At this inspection we found the service remained Good.

At the time of our inspection a manager was employed at the service and was undertaking the registration process with the Care Quality Commission. 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.

There was an organisational policy and procedure for safeguarding people from abuse. Care staff also had the contact details of the London Borough of Islington, which is the authority where the service is located, if any concerns needed to be raised although none had arisen. The members of staff we spoke with said that they had training about protecting adults from abuse, which we verified on training records and each of the staff we spoke with was aware of how to keep people safe.

Potential risks to people using the service were considered, including individual risks and common risks such as the risk of falls and those associated with people's healthcare needs. The instructions for staff about how to minimise risks were clear and updated regularly.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. There were policies, procedures and information available in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards [DoLS] to ensure that people who could not make decisions for themselves were protected.

People were supported to maintain good health. The provider had cancelled the regulated activity of nursing since the previous inspection and any nursing care needed was provided by the local community nursing service. A local GP was available to visit the home if required, although people usually attended the local practice when they needed to. People using the service told us they felt that their healthcare needs were effectively met and gave us examples of how this had been supported by care staff.

People using the service and relatives that we spoke with believed that staff were caring and paid attention to people's needs. The care plan system had undergone improvements which had been helped by the

introduction of a computerised data base which helped to identify when updates and reviews of people's care were needed.

We observed that communication between people using the service, relatives, visitors and staff was engaging and relaxed. Care staff we spoke with expressed commitment to their work and believed they were respected and that their views taken seriously by the provider.

The provider used a range of methods to monitor the effectiveness of the service. These included document reviews to conversations with people using the service, relatives, the staff team and visits from members of the board of trustees.

At this inspection we found that the home was meeting the regulations that we looked at.

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 remains good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service remains good.	**Good**

Queen Elizabeth II Infirmary

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 was unannounced which meant the provider and staff did not know we were coming. The inspection took place on 9 and 15 November 2018 and was carried out by one inspector.

Before the inspection we looked at notifications that we may have received and communications with people, their relatives and other professionals, such as the local authority safeguarding and commissioning teams as well as other health and social care professionals.

We gathered evidence of people's experiences by talking with three people using the service [two in passing who did not wish to speak at length and a third person who did], two relatives and by reviewing communication that staff had with people's families, advocates and other care professionals. We also spoke with the nominated individual for the provider organisation, registered manager, deputy manager three members of the care staff team and a visiting tissue viability nurse.

As part of this inspection we reviewed three people's care plans. We looked at medicines management, training, appraisal and supervision records for the staff team. We reviewed other records such as complaints information, quality monitoring and audit information, maintenance, safety and fire records.

Good

Is the service safe?

Our findings

The comments that we received from people living at the home, relatives and a visiting healthcare professional about the service were positive. A person using the service told us, "I have never had a problem with how staff behave, I am very much a people person and staff here are delightful."

Relatives told us "[Relative] needs to take medicines and staff do help, they do that so well" and "I have never had any concerns and can always talk with staff. I was concerned recently about my [relative's] sleep patterns and that was listened to and discussed with us to see what we could do."

The provider had a policy and procedure for safeguarding people from abuse., which was readily available and known about by all staff. They also had the contact details of the London Borough of Islington, which is the authority where the service is located, in case any concerns arose although none had. The members of the care staff team we spoke with told us of their awareness about protecting people from abuse, the action they would take if they were concerned and were clear about their responsibility to safeguard people from harm. Training records showed that all staff had received training about safeguarding people from abuse. A member of the care staff team told us "This is unique and so different to where I have worked before, it really is focused on people."

Everyone we spoke with, using the service and their relatives, thought there were suitable numbers of staff. Staff all told us that there were enough staff at different times of day to care for people. During our inspection there were suitable numbers of staff available to meet people's needs.

We discussed staff recruitment since our previous inspection with the human resources manager. Eight staff had been recruited, most being bank staff used on an occasional basis, in addition to the registered manager. We looked at the recruitment checks for five of the care staff. Appropriate background checks, Disclosure and Barring Service [DBS] which included a check of criminal records, qualifications and verification of references had been carried out.

Where people were identified as at risk of deterioration in their health or by day to day activities, there were clear assessments and plans in place to mitigate these risks. Action that was identified to minimise risks, for example prevention of pressure ulcers, was taken and risk assessments were regularly reviewed.

People were supported with their medicines and these were stored safely. Medicines Administration Record charts [MAR] had been fully completed by staff. The records showed that people had received all their medicines as prescribed at the correct times of day. Staff were trained in supporting people with their medicine and there were guidelines in place for them to follow. Records showed staff had followed this guidance and the service also audited the management of medicines.

During our visit we checked the communal areas of the service which were clean and well maintained. Health and safety checks of the building were carried out and the appropriate certificates and records were in place. The provider had an emergency contingency plan which detailed what procedures to follow and

who to contact in the event of unforeseen emergencies or events that may impact on the care provided.

Good

Is the service effective?

Our findings

Staff told us they had effective training and complimented the range and variety of training opportunities available to them. Staff participated in regular supervision and appraisal to ensure they had the support and skills to meet the needs of people using the service. Staff told us they received supervision every three months. Supervision records showed this was happening consistently.

Staff attended regular training which included safeguarding adults, moving and handling, mental capacity and health and safety. Staff told us "Since the start of my induction a few weeks ago I have met with [registered manager} three times to discuss how things are" and another told us "I was told everything I needed to know and am being supported to complete the care certificate which I should complete shortly."

People who lacked mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this was in their best interests and legally authorised under the Mental Capacity Act 2005 [MCA]. The 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 whether any conditions on authorisations to deprive a person of their liberty were being met. The staff we spoke with understood their responsibilities under the Mental Capacity Act [MCA] 2005. Staff were also aware of the Deprivation of Liberty Safeguards [DoLS] and how this applied to the service. One person using the service at present was subject to restriction of their liberty under DoLS.

Care plans had the correct forms in place recording decisions about resuscitation choices where this was relevant. Decisions were reviewed by the GP, discussed with the person in question and, if necessary, with relatives.

People did not make much comment about food but those that did thought it was of good quality and varied. One person told us that their relative had recently lost weight but that was due to a better diet as they were now much closer to their preferred weight. Another person told us their relative had put on weight which was a good thing as their diet had previously not been that good when they had lived on their own. People had the option to eat in a main dining room on the ground floor or in the dining room on the floor where the home is located. People could have their meals at a time of their choosing, which we observed, and were not required to adhere to the dining times at the home.

Nutritionist advice was available from local health care services when required. We were told by the nominated individual and registered manager that much had been done in the last year, in consultation with people using the service, to design a healthier and more varied menu.

Relatives told us they were kept updated about their relatives' progress and anything affecting them as well as being able to raise questions and explore their relative's care provision in consultation with staff at the service.

People were supported to maintain their general health. Nursing care was no longer provided and when nursing input was required this was provided by the local community nursing service. A local GP was available to visit the home if required, although where possible people went to visit the GP at the surgery. Healthcare needs were responded to and staff discussed people's current state of health daily, which we observed taking place during a staff handover meeting. A physiotherapist visited the home twice each week to carry out movement and exercise classes, which was taking place on the first day of our inspection.

The service was not providing end of life care to any person at present but had detailed procedures to manage this if it was required. These procedures including liaison with palliative care nursing specialists. The guidelines for staff emphasised that the focus of end of life care was on supporting a dignified death for the person as well as supporting their families and friends. Staff we spoke with were clearly familiar with what they should do to make this difficult time comfortable and supportive for all concerned.

Good

Is the service caring?

Our findings

People, relatives and visitors were overwhelmingly complimentary about the care provided by the staff team. A person using the service told us "Staff are very professional and being here feels so caring [referring to the approach of staff]."

Relatives told us "People are so friendly, everyone is and the staff so very much so" and "Staff are peaceful, calm, friendly and courteous." There was a steady flow of visitors on the days of our inspection. Relatives and other visitors were greeted warmly and attentively by staff.

Three people invited us into their rooms. All rooms were personalised according to what each person preferred. People could bring their own furniture and other personal items within reason and each bedroom was spacious.

Members of staff team told us about how they sought the views and wishes of people who used the service. They told us "We can spend time with people other than just assisting with care which means we get to know each person" and "We are always talking about what we can do for people and how to improve things." Care plans described people's cultural heritage as well as whether people chose to adhere to a religious faith and needed support to do this. We observed staff constantly communicating with people and checking with them before and during providing assistance.

Throughout the inspection, staff were observed talking with people in a calm and friendly manner, requests for assistance were responded to speedily. All staff we spoke with, both care and senior staff, knew people well and were readily able to tell us about each person and their support needs.
A relative told us "I am very much involved in care planning, very much so."

The provider had a clear and detailed policy about acknowledging and respecting people's unique heritage and individuality, including working with lesbian, gay, bisexual and transgendered people. Staff we spoke with were clear about their duty to treat people with respect and dignity. The client group of the service were traditionally from white European backgrounds although the service was looking at how the use of the on-site charitable housing [from where client's traditionally came from prior to using the service] could be more widely advertised to other communities. No one, whether using the service or relatives, had any concern about how they were treated and said that they were respected, and their dignity was upheld.

Good

Is the service responsive?

Our findings

Almost exclusively, the people who move into the home are those who had previous lived in their own accommodation within Charterhouse, which is the charitable organisation that also runs the home. No one was placed by health or social care authorities and all were either self-funding or financially supported by the charity. A relative told us "They helped [relative] settle in so well and took time to make sure this happened."

People told us that they knew about activities that took place and that a range of activities and events were offered. People were not expected to participate as it was their free choice to do so if the wished to. Music, art and dance sessions were held regularly as well as physiotherapy input to help people maintain mobility. A relative commented how much their relative's mobility had improved since moving into the home. Another told us "I am so grateful that so much is arranged, and social events are indeed very sociable."

Care plans showed that the service had effective and positive relationships with other health and social care professionals. The care provided was responsive to people's needs and the service was proactive in identifying changes to need, which were acted upon. As an example, changes to healthcare and support required after medical treatment and encouraging people to remain active and mobile were each responded to. Care plans were clearly written and were accessible to people using the service.

People's care plans were in the process of being transferred to an electronic care planning system which we were shown. Care plans included information about life history, cultural and religious heritage, daily activities and communication. Care plans were reviewed at least three monthly and updated more frequently if this was required. The additional benefit of the electronic database for recording care plans was that it helped staff to identify what elements needed to be updated at more regular intervals depending on each person current health and daily care needs.

People felt confident they could complain and all expressed trust in being able to approach the manager and other staff. Relatives told us "I would always be able to talk with [manager] and I am listened to" and "[talking about the activities and engagement their relative has] my relative would never be able to do these things if it were not that staff look after him so well."

One formal complaint had been made to the home since our previous inspection. This was about a repair which had been responded to appropriately. Apart from this the service had received three emails complimenting the standard of care and the staff team as well as a few 'thank you' cards praising the service. The provider had a clear complaints and comments system which was reviewed by the manager and the service provider.

Good

Is the service well-led?

Our findings

A person using the service told us, "Since my previous experience of living here for a short time it is far more open and professional, as well as feeling homelier."

Staff felt there was trust and openness in communication between the team and senior staff, including the manager and nominated individual. Each member of staff we spoke with was adamant that they would not hesitate to raise any concern or share their views with any member of the senior management team and felt they would be taken seriously and listened to.

There was a clear management structure in place and staff roles and responsibilities were well understood by the staff we spoke with. People's views were respected which was confirmed by those either living at the service and relatives who we spoke with. There were regular staff team meetings, where staff had the opportunity to discuss care at the home and other topics such as how the service was moving forward and developing.

The provider had a system for monitoring the quality of care. There were systems in place to regularly gather the views of people using the service, relatives and others. Relatives who were visiting during our inspection told us that they are asked for their views. There were quarterly "resident and relative" meetings, which was also used as an opportunity to gather feedback. We viewed the minutes of the meetings held in the last year and these demonstrated that information was shared with people and that people's views were acknowledged and taken forward.

Audits of care plans, medicines, staff training, and appraisals took place as well as weekly senior management team meetings to discuss and monitor the day to day performance of the service.

Written feedback was also requested from those people who were unable to visit their relative or friend regularly. The views expressed, either in person or by written response, were recorded and discussed at the weekly senior management team meeting held by the provider. Feedback was also discussed by the trustees (known as the Governors) of the charity running the service and regular personal contact was made between them and the people using the service.

The provider did not publish feedback that was received about the service. There were checks and balances in place to ensure good governance and oversight of the service to maintain a high-quality standard of safety and care.