Queen Alexandra Hospital Home

The Queen Alexandra Hospital Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 8 and 9 October 2014 and was an unannounced inspection.

Queen Alexandra Hospital Home provides a multi-disciplinary approach to care and rehabilitation of people with neurological and medical disabilities, predominantly, but not exclusively, to people who have served with HM Forces or who had relatives in the forces. The service is registered to provide nursing care for up to 60 people, on a short or long-term basis. Queen Alexandra Hospital Home has three wards: Alexandra, Norfolk (North) and Norfolk (South). At the time of our visit there were 53 people living at the service, with two people in hospital. The service is exceptionally well-equipped to aid rehabilitation of people back into the community, if appropriate, and to promote independence. Premises are purpose-built to meet people's needs.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

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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.

People told us that they felt safe and described a feeling of warmth as they came through the door. Staff had received safeguarding training and knew how to recognise the different types of abuse and what action they would take should they suspect abuse was taking place. Physical restraint was not used, except for wheelchair users, to prevent falls from occurring and for people with acquired brain injury, to prevent them from pulling out intravenous lines. Best interest decisions were taken as needed to ensure that people were not restricted unnecessarily. The service followed the requirements under Deprivation of Liberty Safeguards (DoLS). Accidents and incidents were recorded and reported in a timely manner, lessons learned and action taken to prevent reoccurrence. Staffing levels were sufficient to keep people safe and meet their needs. Staff said, "You do get time to spend with everyone, you get to know everyone". Staff were recruited and references and checks undertaken, including criminal records to ensure they were safe to work with people. People's medicines were administered, managed, stored and disposed of safely. We observed the administration of medicines and that people were asked for their consent before receiving their medicines.

The service delivered an outstanding and effective level of care. People's nutritional needs were monitored and a dietician's services were bought in to ensure people received individualised nutritional care. People were on diets that were tailored to meet their individual needs. Staff were extremely attentive when supporting people to eat their meals and there was a relaxed, warm and friendly atmosphere in the dining room. Access to healthcare services was readily available both internally and externally. The service employed the service of an occupational therapist, speech and language therapist, neuro-psychologist and others. A GP visited twice a week. There was a holistic approach to people's care. People had access to regular physiotherapy sessions with trained staff in a centre that had equipment such as a treadmill, balancing machine and walking rails. The service had exceptionally well equipped and purpose-built premises so that people could be provided with high quality support that met their individual needs and promoted their independence.

Staff were fully trained in essential areas and also in specific areas to ensure that people's complex needs were met effectively. People's capacity was assessed prior to admission to ensure that their needs were met at the point of admission. The provider was pro-active in their approach to ensure that staff were trained in any additional areas as required, so people's needs could be met swiftly. Assessments were undertaken by a neuro-psychologist when people entered the service. This specialist was funded by the service which meant that people's needs could be assessed promptly and support and treatment could be commenced without delay. People were able to come and go as they pleased and could access the community freely.

Staff knew people very well and said, "I love working here. You really get to know the patients well". One person said, "I love being here and the grounds are amazing". People spoke very highly of the staff and the care that they received. Staff communicated effectively with people who had little or no verbal communication and involved them in all aspects of their care. An emphasis was on people being supported to be as independent as possible. Work was in progress to build a wheelchair clinic to review and repair wheelchairs. Relatives were encouraged to be involved in their family member's care and could visit whenever they wished. Staff were trained in end of life care and people and those that mattered to them were fully involved in planning the care they wished as they came to the end of their lives. There was a multi-denominational chapel on site and a chaplain provided people with spiritual and emotional support if they wished.

The service was responsive to people's needs – with their care needs and with arrangements to prevent them from being at risk of social isolation. People's care needs were reviewed regularly by a range of professionals, including a multi-disciplinary team. There was a range of activities on offer at the service, for example, craftwork, painting and sewing. staff. Outings were organised to London and a

Summary of findings

specially equipped coach ensured that wheelchair users could also access the community. People knew how to raise any concerns and complaints were dealt with in a timely manner.

People were actively involved in developing the service and their views and opinions were sought and acted upon. Questionnaires showed that people were very positive about all aspects of their care. Fundraising was a major factor in providing the excellent quality of care and the service had a team dedicated to raising funds. This funding enabled people to receive services from a range of specialists so that individualised care and treatment could be delivered speedily. Funding also subsidised outings and was used to provide state of the art facilities at the service. Staff surveys showed that staff were happy in their roles and felt supported. Senior managers were overseen by a Board of Directors who took an active part in overseeing the service and visited regularly. Effective quality assurance processes and procedures ensured that every aspect of the service was audited to maintain a high quality service and also to identify any improvements that would help to maintain and raise the quality of service and care provided. The service worked with a range of other organisations and staff were kept up to date about latest guidance for delivery of care and treatment.

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?

Good

The service was safe.

People said they felt safe and staff were trained in safeguarding so that they could recognise the signs of abuse and knew what action to take. Where people were identified as at risk, the service had taken appropriate steps to address this.

Medicines were ordered, stored, administered and disposed of safely.

Staffing numbers were at levels that helped ensure people were safe.

Accidents and incidents were recorded, lessons learned and action taken to reduce the risk of re-occurrence.

Is the service effective?

Outstanding

The service was effective.

People's capacity to make decisions was assessed at the point of admission and regularly reviewed. This meant that decisions could be made without delay and that prompt action was taken, to ensure people received effective care.

People's nutritional needs were monitored and they had access to home-cooked food and drinks that promoted their well-being. Mealtimes were a pleasurable experience. They had access to on-site speech and language therapy support and to a dietician, so that all aspects of their dietary care was catered for.

People had access to healthcare services and to a range of healthcare professionals on site. Premises were purpose-built and exceptionally well equipped to encourage rehabilitation and independence of people using the service.

Staff received a comprehensive induction and ongoing essential and additional training. The service had processes in place that ensured staff were kept up-to-date on their training needs.

Is the service caring?

Good

The service was caring.

People spoke highly of the staff and the care they received. Staff were able to communicate effectively with people who had little or no verbal communication.

People were encouraged to be as independent as possible through a variety of support mechanisms and rehabilitation was a key focus of the service.

People were supported at the end of their lives to have a pain-free, comfortable and dignified death. They were involved in decisions relating to their end of life treatment, as were people that mattered to them. A multi-denominational chapel on site and a chaplain could provide support for people's emotional and spiritual needs.

Summary of findings

Relatives were encouraged to be involved in their family member's care and could visit whenever they wished.

Is the service responsive?

Good

The service was responsive.

People's care needs were reviewed and updated regularly by care staff and a range of professionals from the multi-disciplinary team.

There was a system in place to ensure that complaints were dealt with and resolved in a timely manner.

There was a dedicated social and recreational area where people could follow the hobbies of their choice. There were organised outings into the community.

Is the service well-led?

Good

The service was well-led.

People were actively involved in developing the service through residents' meetings. Their comments were collected in an annual questionnaire and action taken. Staff surveys showed that overall people were positive about working at the service and felt supported.

There were robust quality assurance systems in place that ensured all aspects of the service were monitored.

Fundraising by a dedicated team was intrinsic to the service and enabled the delivery of outstanding care from highly trained staff and through state of the art accommodation and equipment.

Management were supported by directors who were actively involved in the strategic direction of the service and visited the service regularly.

The Queen Alexandra Hospital Home

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 checked 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.

The inspection took place on 8 October 2014 and was unannounced.

Three inspectors and an expert by experience in physical disability undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We reviewed the Provider Information Return (PIR) and previous inspection reports before the inspection. The PIR was information given to us by the provider. This enabled us to ensure we were addressing potential areas of concern and highlight what the service does well.

We observed care and spoke with people, their relatives and staff. We also spent time looking at records, including six care records, three staff files, medication administration record (MAR) sheets and other records relating to the management of the service. We looked at notifications that CQC had received from the provider.

On the day of our inspection, we spoke with ten people, one relative, the registered manager (matron), the chief executive, five registered nurses, seven care staff and other staff involved in running the service, social and recreational supervisor, physiotherapist, head chef and dining room supervisor. After the inspection, we contacted three healthcare professionals to ask for their views of the service.

Queen Alexandra Hospital Home was last inspected on 28 October 2013 and there were no concerns.

Good

Is the service safe?

Our findings

People we spoke with said they felt safe. One said, "I feel safe. As you come in the door you can feel there is warmth here". External CCTV cameras enabled security staff to oversee the extensive grounds and helped to ensure people were safe.

As far as possible, people were protected from the risks of abuse and harm. Staff spoke positively about the safeguarding training and support they had received. They understood the different types of abuse and described the action they would take if they suspected abuse was taking place. There were policies in place for staff to refer to and they knew how to access these.

Staff received training in behaviour that challenged [challenging behaviour] which was delivered by the registered manager. The manager had qualifications that enabled her to deliver this training. Physical restraint was used, for wheelchair belts and bed rails where needed, to prevent people who were at risk from falls and keep them safe. Where appropriate, best interest decisions had been taken. Some people, for example those with acquired brain injury (ABI), had worn safety mittens to prevent them pulling out intravenous lines and plugs. People's needs had been assessed appropriately in these areas and risk assessments drawn up.

Accidents and incidents were reported by staff in a timely manner and there were policies and procedures in place relating to this. Each part of the service, or ward, kept a copy of the policies and procedures and staff had signed these to show they had been read. When an accident or incident occurred, this was investigated and a copy sent to the chief executive. If an accident or incident related to a person using the service, then a copy of the incident was placed on their care record. There were systems in place to ensure that risk assessments were reviewed as a result of the incident, lessons learned and changes made if needed. Staff knew how to report incidents and were confident that action would be taken. They told us that any incidents that had occurred were discussed at handover, when staff changed shifts. One member of care staff told us, "If someone was falling regularly, we look at options. For example, moving furniture around or seeing if they'd like to move rooms to be nearer the nurses' station. Changes are made and put in place to help us prevent it happening again". Risks were managed appropriately when identified so that people were protected and their freedom was supported and respected.

Where people were at risk of pressure sores, appropriate steps were taken. For example, a pressure mattress was used for one person and the required settings of the mattress were recorded in their care plan. Care records showed that risk assessments were in place for areas such as malnutrition, developing pressure sores, mobility, falls and moving and handling. These were reviewed monthly or sooner if people's needs changed.

There were sufficient numbers of suitable staff to keep people safe and meet their needs. There was always at least one registered nurse on duty on each ward who was supported by at least four care staff per ward during the day. Staff told us about the flexible staffing arrangements and the positive impact for one person, with complex needs, when they were provided with one to one support. Agency staff were rarely used, but when needed to ensure safe staffing levels, the service always used the same staff, who knew people well. People said, "No matter what, two staff are left on the ward" and "We all have call bells and we're shown what to push if it is an emergency".

Staff were positive about the staffing levels and they felt that they had time to spend with people and to fit in with people's preferences and routines. One said, "You do get time to spend with everyone. You get to know everyone". Call bells were responded to in a timely manner. Staff checked on people and asked them if there was anything they needed.

The provider followed safe recruitment practices. Staff records showed that, before they were allowed to start work at the service, checks were made on their previous employment history and with the Disclosure and Barring Service to help ensure new staff were safe to work with people. In addition, two references were obtained from current and past employers and their qualifications were checked in line with information supplied on the application form. Staff confirmed this had been their experience.

There were policies and procedures in place relating to medicines, for example, PRN, controlled drugs, disposal, safe use of medicines when people went on outings and self-medication. Staff had received training in the

Good

Is the service safe?

administration of medicines and this was updated yearly. In addition, spot checks were undertaken when staff administered medicines to ensure they were doing this safely. People's medicines were managed so that they received them safely. In the dining room, we observed a member of care staff ask if a person was ready for his medicines. He agreed and the care staff went to fetch it. She returned with the medicines which he took. The care staff was discreet and showed respect to the person. Another person was offered a dose of laxative and this was handled politely and in a sensitive manner.

We observed the medicines being administered at lunchtime. People were asked for their consent and assisted as required. PRN (medicines that were taken as needed) were offered and explained to people. For example, people were asked if they would like any painkillers and information given to help them make an informed choice. MAR sheets were completed and signed off appropriately as medicines were administered to people. The MAR sheets also included instructions on how the medicine should be administered, for example, 'Dissolve in water and give via peg". A percutaneous endoscopic gastrostomy (PEG) is a tube that feeds directly into a person's stomach. This meant that comprehensive information was provided to staff so that people's medical needs were met safely.

Records related to received medicines and their disposal were kept appropriately. Medicines that needed to be refrigerated were stored in fridges at the appropriate temperature to keep them effective. There was a controlled medicines register which recorded medicines received and stock levels audited. Controlled drugs are subject to legislative control. Controlled drugs were stored safely in a separate locked container within the medicines store. Medicines were also stored in lockable containers in people's rooms if they were needed in an emergency or if people administered their own medicines. There was a specimen signature sheet which staff who had been trained to administer medicines had signed. We were told that, if a person refused their medicine, then this would be offered again later. This was recorded on the MAR sheets. Where people were able to administer their own medicines, they were risk assessed to support them to do this safely.

Outstanding ☆

Is the service effective?

Our findings

People had information and explanations provided to them about their healthcare and there was evidence of this on their care records. One person told us they had been at the service for about a year and explained they had their own nurse and keyworker. (A keyworker is someone who co-ordinates all aspects of a person's care.) He felt that everything was explained to him and that he had input into his care. If there was something he did not understand, then this was explained to him through the use of pictures. He felt he was listened to by staff and his views were taken into account.

People's nutritional needs were monitored through the use of the Malnutrition Universal Screening Tool (MUST) and information was recorded in people's care plans. A dietician also attended the service one day per month to provide advice and support. She told us that she had seen some 'fantastic results with some patients' and had observed people progress from requiring full care with a feeding tube in situ, to becoming independently mobile and managing to eat and drink a normal diet with the tube being removed.

We observed people eating their meals in the dining room at lunchtime. Staff told us about one person who was struggling to eat independently and they held the bowl just below their chin. They asked the person if they were happy with that and the person said 'yes'. Staff were overheard chatting naturally with people, for example, asking about their plans for the day. The dining room was light and airy and there was a relaxed atmosphere. It was spacious to accommodate wheelchairs. Tables were laid with salt and pepper, serviettes and cups and saucers. There were different coloured place mats which provided discrete information for staff. For example, if a person was diabetic, at risk of choking, required assistance or were able to eat independently, different coloured mats indicated this. There was also a folder with guidance for staff about how to support people in the dining room, with advice from a speech and language therapist.

There was a variety of meals on offer, including hot and cold options. One gentleman had a bottle of wine on the table and this was his personal choice. There were plenty of staff to support people as needed and some people were chatting amongst themselves. Staff were quick to notice when people needed attention, for example, when a fork was dropped, they were there immediately and returned with a clean one. We met with the head chef who told us that people were actively involved in drawing up the four weekly menus. People ordered their food and their choices were recorded on sheets for each ward. These sheets also recorded which people required special diets so that choices could be made accordingly. People could choose what they wanted to eat in line with their personal preferences. There were a range of alternatives available, so people could change their minds about their food choice later in the dining room if they wanted to. The kitchens had been refurbished recently to an exceptionally high standard and this enabled staff to deliver food that was nourishing, tasty, freshly cooked and met people's individual dietary requirements. There was an environmental health inspector undertaking an inspection of the kitchens on the day of our visit; the service received the highest rating of five .

People were supported to maintain good health, had access to healthcare services and received ongoing health support. There were healthcare professionals on site to support people's healthcare needs. Physiotherapy was available and a room was dedicated to help people keep fit and exercise to aid rehabilitation. We saw people working hard at their exercises and enjoying the sessions. There was a treadmill, balancing machine, walking rails, bikes and stairs. The emphasis was to enable people to attain fitness, maintain or promote mobility and on rehabilitation. A GP visited the service twice a week and treated people in a separate room to protect their privacy. Where necessary, healthcare professionals could make referrals for people to see specialists. A district nurse came in to deliver people's flu jabs and, if needed, people were taken by staff to attend hospital appointments. There was also access to additional healthcare professionals such as podiatrists or opticians and there was evidence of this within people's care records.

Queen Alexandra Hospital Home was fully equipped to support people with a range of needs and disability through state of the art accommodation. The premises had been designed to support people's individual needs. As people left the dining room after lunch, they were supported to leave and asked where they would like to go. Others left independently, some using powered chairs driven either by hand or through chin switches. The accommodation was purpose-built to enable people to be as independent as possible. People told us that they were very satisfied with the premises and had been involved in

Is the service effective?

planning any refurbishment. For example, there was a 'rehab kitchen' which had been equipped to meet the needs of wheelchair users, with adjustable work surfaces and floor space that allowed for people to manoeuvre easily around the kitchen. This facility promoted people's independence when undertaking cooking or kitchen chores. One person, who enjoyed cooking, told us, "It's all made so that we can go under it [work surfaces], which adjust to whatever height you need". People's rooms had profiling or bariatric beds, hoists and overhead tracking. (People often require specialised beds in order to support their frame, enable access, let nursing staff move them safely and to provide comfort for people who are confined to bed and who are recovering from illness or surgery.) People had TVs and access to the Internet. There was underfloor heating, corridors were wide and lifts large enough to accommodate stretchers. There were no carpets so that wheelchairs could be propelled easily around the service. There were rooms dedicated to recharging electric wheelchairs or scooters and records showed when batteries were charged. This meant that people were not restricted in their mobility as they always had access to an operational mode of transport. Other facilities included a library, a sensory room, an orangery and ramps to gardens with raised flowerbeds, enabling people to do gardening, with support from gardeners. These additional facilities also provided space for people to spend quiet time or to meet with people privately. Bathrooms were large, light and airy with a range of equipment to support people with complex needs

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. New staff undertook a comprehensive induction training programme – nurses' induction was two days and other support staff was one and a half days. There was a detailed induction pack for staff which gave a brief history of the service, the objectives, fire alarm procedures and a planner. The planner comprised separate modules relating to various topics, for example 'Your Work Area' and 'Security' and enabled staff to complete their induction step-by-step. New staff then had to sign off the different modules to confirm that they had covered and understood all the necessary items in the module. There were also opportunities for new staff to shadow existing staff so they could learn and understand about their job role. Staff said, "When I started I was supervised at all times. The support was brilliant". Another said, "You're given a mentor so you have someone you can go to".

Essential staff training covered, for example, dementia care, challenging behaviour, safeguarding of adults, moving and handling, health and safety and infection control. All care staff had to complete a National Vocational Qualification (NVQ) Level 2 (or Qualification and Credits Framework equivalent qualification) in Health and Social Care. Staff then progressed to NVQ Level 3. Nursing and care staff also underwent training in basic life support. Additional training was delivered in areas such as continence, tissue viability, end of life care, attention and memory cognition and first aid at work. Staff were fully trained on specific topics prior to people being admitted to the service so that they could know how to address people's particular needs straightaway. For example, training had been organised relating to people with a tracheostomy (which is an incision to the windpipe to aid breathing) and peg feeding through a tube in the abdomen. This ensured that people could receive care that was effective and fully met their needs. 'Back to Basics' training was also offered every six months which allowed staff to refocus on the training they had already received.

The training plan listed all staff, the training they had undertaken and when this training needed to be updated or refreshed. The plan highlighted in green when training was current and flashed up purple on the computer when this training needed to be refreshed. This provided a clear visual indicator to the staff member responsible for arranging training and ensured that staff were up-to-date with their training. Staff were informed about training they needed to undertake approximately four to six weeks beforehand. If staff did not attend the training, then a letter was sent out to remind them that they had not attended and another training session was arranged. If staff still did not attend, then disciplinary action would be taken. Staff confirmed to us that they had received all essential training and that there were opportunities for care staff to progress to the role of care supervisor or medical training outside of the organisation. A registered nurse told us that she had received all the training she needed and mentioned training in tracheostomy care, catheter care and taking bloods. People received care from staff who were appropriately trained to meet their needs effectively and that staff were up-to-date on current practices.

Outstanding ☆

Is the service effective?

The service provided training and work experience for students training to be registered nurses from the Ministry of Defence (MoD). Students with an MoD background were involved in looking after people who served in the forces and with rehabilitation programmes that supported people to live more independently. The service provided a unique opportunity for students to learn more about this specialised, rehabilitative care. Opportunities were also provided for physiotherapy students at university to gain work experience. Students undertook a comprehensive induction programme provided by the service prior to joining, so that they understood exactly what sort of care and support the service delivered and how they could complement this. Work experience or work shadowing was also available to local school pupils who could shadow work undertaken by physiotherapists, occupational therapists or in the social and recreational area. The service had identified opportunities for people to learn about job opportunities, and the kind of career that they might be interested in, across a range of disciplines. They worked closely with local secondary schools and supported pupils whilst they were undertaking work experience programmes. People were cared for and supported by people from a range of backgrounds. This resulted in new ideas that could contribute towards more innovative care planning for people.

People received care from staff who were supported by management. Staff received regular supervisions at least every two months. Staff confirmed this to be the case and staff records showed copies of supervision notes and items that had been discussed. New staff received supervisions on a monthly basis for the first six months. Staff received annual performance development reviews to assess their overall performance.

People were assessed at the time they were admitted to the service. Mental capacity assessments were undertaken by a neuro-psychologist who was funded by the service. People with an ABI were, therefore, assessed promptly rather than having to wait for public services. This meant that their care needs could be identified early on and care and treatment delivered swiftly. People were assessed on their capacity to make day-to-day decisions and more complex planning decisions. Assessments were reviewed regularly as people's capacity changed. Where people needed support to make decisions, the provider recruited advocates to help them. Advocates could be recruited from a charity that supported ex-service people and understood their particular issues and needs.

Where people were assessed as not having capacity to make their own decisions, then a best interest meeting would be held. Best interest meetings were convened, relevant professionals and relatives invited and a decision taken on a person's behalf. For example, a best interests meeting was held for one person and a decision reached with their relative, about where the person should live when they left Queen Alexandra Hospital Home. The majority of staff had received training about the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and had a good working knowledge of these. Office and other support staff, who had no direct contact with people, were not required to undertake this training. No-one at the service was subject to a DoLS authorisation. There were policies and procedures in place in relation to the requirements of the MCA and staff knew what their responsibilities were and what actions to take. There were no restrictions on people's movements and they could leave the service when they wanted, as long as they signed in and out. Staff were then aware of people's movements and whether they were at the service or not. Staff or people's relatives would provide assistance if needed when people wanted to go out.

Good

Is the service caring?

Our findings

People had a named nurse and keyworker allocated to them to oversee all aspects of their care. Some people had direct connections with the forces or had a family connection with the forces. Staff were extremely attentive towards people, understood their particular needs and their backgrounds and engaged with them positively. They took time with people, sat with them or bent down so that they were at the same level. This was important for people who spent time in their wheelchairs. People told us, "They're [staff] are all so nice and kind." Another said, "They're really good" and, "The care staff are marvellous – they do a good job overall". People were asked what they wished to do or where they wanted to go. Some people stayed in their rooms, others were involved with social or recreational activities or were in physiotherapy doing exercises. Others could receive visitors or chat in the coffee bar area. There were newspapers for people to read and drinks and light snacks were available from the coffee bar.

Staff were able to communicate effectively with people who had no verbal communication or who had communication difficulties. A healthcare professional told us that staff were very good at speaking and communicating with people in a personalised way. They confirmed that care staff really knew their patients and gave them lots of detailed information. We talked with a person who shared a room with someone who was unable to communicate verbally. He told us, "They'll [staff] either show him a picture or put in writing what they're going to do. They will ask and explain what's going on. They'll explain to you and ask if you agree to it". One staff member told us, "We actually have time to care here, it's so different from other places I've worked". Staff felt they were able to make suggestions about people's care. For example, one person did not appear to be comfortable in his chair, so the staff member arranged for a review and improvements were made. They told us, "At handover, I can say if I feel something is not right".

People were treated with dignity and respect. Staff knocked on people's doors before entering. Nursing procedures and personal care was undertaken in the privacy of people's rooms or in a discreet manner in other areas of the service.

A relative had Power of Attorney over their relative's affairs and felt fully included in their care. All the therapies that they had received had been fully explained to both of them. People had access to advocates if they were needed and the service had connections with a charity to provide these. Relatives could visit without restriction. A relative told us that they were encouraged to take an active part in their daughter's care and would also help her with lunch. They said they could take her out into the community whenever they wished to do so and would spend the whole day with her when they came to visit.

Staff told us that promoting people's independence and working towards rehabilitation was a key focus. They said that they had time and that they did not feel they had to rush people. One said, "One of the main priorities is to promote as much independence as possible. It might take a little longer in the short term, but that's what we're here for. It's so important".

People, and those that mattered to them, were involved in their end of life care and care records confirmed that discussions had taken place, who had been involved and the date this needed to be reviewed. Staff had completed the Gold Standards Framework for End of Life Care training, which is a recognised national standard. The training aimed to support staff to provide quality care for all people in the final years of life, enabling them to live well and die where they choose, reducing inappropriate hospitalisation. The accreditation process involved continuous assessment against 20 standards of best practice across a two year period and an official inspection visit at the end. People also had advanced care plans which gave detailed information about the care they wished to receive and enabled better planning and provision of their care as they reached the end of their lives. Staff were clear on people's end of life wishes, for example, whether they wanted any visits from clergy or other religious representatives. There were no people of faiths other than Christian or cultures living at the service. However, staff told us about how they had supported people in the past from different faiths. They told us, "We used to have a Buddhist and we'd arrange transport to go to the temple in Hove". Queen Alexandra Hospital Home had a multi-denominational chapel on site which was open to people every day should they wish to use it. The chapel was also available for funerals or other services and had recently recruited a chaplain who would provide spiritual and emotional support to people, staff and relatives should they wish to access it.

Good

Is the service responsive?

Our findings

People received personalised care and a tailored rehabilitation programme that was responsive to their needs and detailed care records showed this. We spoke with registered nurses who had a good understanding of people's needs and preferences. Assessments were undertaken by the ward manager and specialist staff from the multi-disciplinary team. People's needs were reviewed regularly and people were involved in these reviews. These involved a full multi-disciplinary review annually, when the physiotherapist, occupational therapist, speech and language therapist, neuro-psychologist, dietician and social workers would discuss people's care. Following these reviews, a report would be shared with other healthcare professionals as well as the person and their relatives.

Other reviews took place more regularly, for example every quarter, and involved people, their keyworkers who co-ordinated their care, other care staff and relatives. One person talked about their review meeting and said, "We have a meeting to see what else they can do to help us, to see if they can help us go a little bit further than what we're doing". Another person described their therapy and how they were trying to regain their fitness. He said, "We do cooking, we cook all kinds of things. The physio's are very good. I've lost weight and they're working to build it up".

Care plans included detailed information about people's personal care and how their needs should be met, for example, on personal care, catheters, and tracheostomies. Some areas were reviewed on a daily basis and others every four days, for example, tissue viability.

The neuro-psychologist visited for two or three days per month and provided cognitive and psychiatric support on site. Counselling could be accessed if needed and support provided to help people combat stress connected with post-traumatic stress disorder. Caseworkers could also be called upon from a charity which supported ex-service men and women to provide one to one support for people.

Staff told us, "You have to get to know their preferences and routines. There are people who like things done a certain way. We go by what they want". Another staff member said, "You get to know people and can give individual care. People are given freedom in how and when they want to do things". Where people had difficulty in verbal communication, they could indicate their preferences in a physical way, for example, one person used 'thumbs-up' to indicate his agreement.

People were able to follow interests and hobbies of their choice and were supported in this by the occupational therapist and a dedicated activities co-ordinator. There was a large social and recreational area which was wheelchair accessible. On our visit, we saw people engaged in a range of activities – painting, craftwork, collages – many were making decorations for Christmas. The social and recreational area was well equipped with sewing machines and painting materials, for example. There were residents' meetings chaired by the registered manager at which people could discuss their hobbies and the outings they would like to have organised. People's suggestions were acted upon where possible and people felt they were listened to.

People were able to access the community freely and there were also outings organised should people wish to be involved. There was a coach that had been equipped to accommodate wheelchair users so everyone who was well enough could go out. Outings had been organised in the past to Garden Parties at Buckingham Palace and some people had attended a tea party at Clarence House. People told us, "They give us trips out. We are going to Lakeside shopping. We go to the Cenotaph". People were able to choose the kinds of outings they wanted to go on. Another person said, "We go on some nice trips and we get lots of people in: singer, actors. They have plenty on at Christmas, we have some really good times". Remembrance Day was an important event on most people's calendars, especially those with a connection to the services, and several people had signed up to attend the laying of poppies at the Cenotaph. Outings such as these were funded by monies raised by the fundraising team, including charities for ex-service people.

People knew how to raise concerns and said that they felt able to do so. For example, one person gave an example of complaining about a member of staff who they felt had not listened to them. This was raised with the registered manager and a discussion took place with all parties. The staff member offered an apology and the person said things had improved and told us, "If I've got something to say, I'll say it". People were given information on how to raise a complaint in the service user guide which was given

Good

Is the service responsive?

to them on admission to the service. Only one complaint had been recorded for the year. Formal complaints were acknowledged within two days, investigated within 28 days, dealt with effectively and in a timely fashion. Where complaints could not be resolved satisfactorily, contact details were also provided for other agencies. There was a policy in place and all complaints were submitted to the Board of Trustees.

Five beds at the service were kept for people who came in for short breaks; these were offered all year round and booked a year ahead. People coming in to the service for short stays also underwent a comprehensive, personalised assessment prior to admission, similar to those who lived at the service permanently.

Good

Is the service well-led?

Our findings

The provider promoted a positive culture that was person-centred, open, inclusive and empowering. People were actively involved in developing the service. One person had been nominated to sit in on interviews with potential new staff. The manager told us that he was very popular with other people and could represent them. People had completed an annual feedback questionnaire and the results were published in September 2014. The questionnaire asked people about their impressions of the service, their personal care and support, catering and meals, daily living and management of the service. Overall the results were very positive. Where actions had been identified, the provider had put in place recommendations on how these actions should be met. For example, the questionnaire had identified that staff needed to maintain the current high standards of daily living and would encourage people to be involved and share their views at monthly residents' meetings.

People spoke of their involvement in meetings and felt that they were listened to. One said, "The chief [Chief Executive] invites people to give suggestions" and another said, "Matron does ask us to let her know how things are in the meetings that we have". There were no separate meetings or questionnaires sent out to relatives, but they were encouraged to make their views known through their family members. Relatives' meetings held in the past had not been too successful, so they could be involved at residents' meetings if they wished. Notice of residents' meetings were advertised on the main notice board and on the wards.

People were actively involved in fundraising if they chose. For example, there was a darts night held every month with people and staff, which was a fundraising event. Other events were held throughout the year and open to the general public. There was a dedicated fundraising team which funded all aspects of the service, for example, healthcare specialists who could act quickly to ensure that people's needs were met promptly. Apart from funding specialists, the provider also funded outings and activities and refurbishment of the premises. It also received funding from charities supporting ex-service personnel and their families and from legacies and bequests. The service needed to raise at least £1.3 million every year to fund additional care, outings and improvements. In excess of this amount had been achieved. This enabled the service to deliver high quality care.

One person told us about a member of staff who was very knowledgeable about finances and the benefits that people were entitled to. They said, "Any money help or anything like that, she's always there to give you a helping hand. She'll ring up and find out for you. She'll get as much advice as she can for you".

Staff were clear about whistleblowing and who to contact either internally or externally. They felt they could speak freely and did not fear any repercussions. One said, "It's easy to communicate. Matron is always readily available". Another said, "R is my line manager. You really feel that you can talk to him".

An employee satisfaction survey had been undertaken in 2014 and results compared with the survey undertaken in 2013. Out of 123 questionnaires sent out to staff, 72 were completed and returned. These showed that the majority of staff were happy in their role and felt supported. The results showed an overall improvement for the year, compared with the preceding year. Staff told us, "Working here is the best thing I ever did", "The level of care is fantastic", "It's a happy place to work" and, "Everybody works as a team". The matron had an 'open door' policy and staff felt that they were listened to. One said, "She [Matron] always asks if there are any problems" and another said, "If I'm not happy, I do mention it to Matron and things do change".

Staff meetings were held monthly with ward meetings and separate meetings for senior registered nurses. Meeting notes showed that quality assurance was a regular feature, as well as multi-disciplinary team reports, communication, resident dependency and ward establishment.

The service had a mission statement that was shared with people, their relatives and staff – 'It is the mission of the Queen Alexandra Hospital Home to provide a multi-disciplinary approach for the care and rehabilitation of those with neurological and medical disabilities – predominantly for those who have served with HM Forces'. The service user handbook provided people with information about the core values of care and a residents' charter which described what people could expect of staff,

Good

Is the service well-led?

for example, to be called by their preferred name and be involved in planning their care and treatment. The mission and values were embedded into the service and practised by staff.

The registered manager and chief executive were supported by a Board of Directors (or Trustees) who visited the service regularly. Directors had been appointed for their experience in significant areas, such as nursing, finance and pensions. The directors had an oversight of the strategy and finances, whilst the registered manager and chief executive were responsible for operational issues. The service was set up as a limited company and as a charity and produced an annual review which described the purpose and aims of the organisation and progress made throughout the year. There was accountability at all levels and shared responsibility for the operation of the service.

Quality assurance was key to the efficient running of the service and to identify good practice, as well as identify areas for improvement. There was a dedicated member of staff who audited all aspects of the service. Where improvements were required, action had been taken and outcomes recorded. Any patterns in occurrence would be shared with the Board for consideration and recommendations made. For example, if accidents and incidents had occurred at the same time of day, what this showed and what specific action could be taken to prevent these from reoccurring. MAR charts had been audited and prompt action taken when errors had been identified. Care records were audited and clinical staff were reminded of when reviews were needed. Reminders were sent to registered nurses on duty for each ward; these included the person's name, the risk assessment due and the date staff needed to have this completed. These were audited fortnightly and staff had to sign off when the work had been completed. If this was not done within five days, then the matter was referred to management. Advanced care plans were reviewed at least every three months and social and recreational activities were reviewed with residents every couple of months. Catering meetings were also held every two months, to review menu choice and involved people who used the service. This ensured that people received care that met their most up-to-date needs and personal preferences.

Staff were kept up-to-date about current guidance for the delivery of care and treatment because they were given information and updates. For example, latest guidelines from the National Institute for Clinical Excellence.

The provider was in the process of building a wheelchair clinic, a dedicated area which would be completed by the end of 2014. The clinic would enable the review and repairs of wheelchairs and other modes of transport that would promote people's independence. This clinic would also be available to others outside the service and had been funded by an individual donation.

The provider worked in partnership with other agencies. Meetings would take place every quarter with the Clinical Commissioning Group who agreed funding for people for the year ahead. Other meetings, such as review meetings, would be organised that involved other statutory agencies, such as social services. According to the Provider Information Return, the service was a member of West Sussex Forum for Care Homes, Acquired Brain Injury Network, Association of Continence Advice, Royal College of Nursing, Royal Society of Medicine, Local Tissue Viability Management Forum and Local Infection Control Network. This benefited the staff to support their care provision, service development and joined-up care based on best practice.