Epilepsy Society

Queen Elizabeth House

Inspection report

The National Society for Epilepsy
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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

Queen Elizabeth House is a nursing home which provides care for up to twenty people with epilepsy, learning and/or physical disabilities. The home is a purpose built bungalow and consists of an eight bedded and 12 bedded unit. At the time of our inspection there were twenty people living at the service.

There was a registered manager in post. 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.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

At this inspection we found the service remained good.

Relatives were happy with the care and support provided. They had positive relationships with staff and the registered manager. One relative raised concerns with us about some aspects of their family member's care. This was fed back to the provider who told us they were already aware of the complaint and had commenced an investigation.

Systems were in place to safeguard people. Risks to people were identified and managed. Safe medicines and infection control practices were promoted.

Staff were suitably recruited, inducted, trained and supported. The required staffing levels were maintained, although the registered manager recognised continuity of care was difficult to achieve through the high use of agency staff.

People had care plans in place which outlined their needs and support required. Their health and nutritional needs were identified and they had access to a range of health professionals. People were provided with support and equipment to promote their health, well-being and independence.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

Staff were kind and caring. Relatives described staff as "Wonderful, attentive, caring and knew how to support and communicate with their family members."

The provider had systems in place to audit and oversee the running of the service. Internal audits and some

aspects of record keeping were incomplete. The registered manager addressed this immediately to bring about the required improvements.

The registered manager was experienced in their role. They were supportive and acted as a positive role model to staff. They were described as professional, knowledgeable, approachable, good listener and acted on issues raised.

Further information is in the detailed findings below.

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 House

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 the 18 and 19 September 2018 and was unannounced. The inspection was carried out by two inspectors.

Prior to the inspection we requested and received a Provider Information Record (PIR) on the service. The PIR is a form that the provider submits to the Commission which gives us key information about the service, what it does well and what improvements they plan to make. We reviewed other information we held about the service such as notifications and safeguarding alerts. We contacted health care professionals involved with the service to obtain their views about the care provided. Their feedback is included in the report.

People who lived at the service had limited verbal communication and therefore were unable to fully share their view of the service with us. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we walked around the home to review the environment people lived in. We spoke with three people who used the service, the registered manager, deputy manager, four registered nurses, a team leader, six support staff and a housekeeper. We spoke with two sets of relatives during the inspection. After the inspection we spoke with three relatives by telephone and received written feedback from another six relatives.

We looked at a number of records relating to individual's care and the running of the home. These included care plans and medicine records for eight people, shift planners, duty rotas, seven staff recruitment files, staff training and six staff supervision records.

Good

Is the service safe?

Our findings

People continued to receive safe care.

A person told us they liked living there and felt safe. Relatives felt their family members were safe. This was because they were provided with equipment and staff supervision to promote their safety. A relative commented "Queen Elizabeth House has been the happiest and most settled place that [family member's name] has lived. I am so pleased that they have a permanent home there. Although [family member's name] loves visiting home for a few days she is always happy to return to her 'home'."

Another relative commented "Yes I believe my [family member's name] care is safe. We have developed a very good relationship with the staff and between us we have a very open dialogue to discuss their care. It is not always perfect but I really like how proactive the team are to bring any issues to our attention so we can discuss and agree how to overcome them. We have never had a major concern over the safety of care. "

A health professional involved with the service commented, "Residents are safe and protected from abuse or improper treatment "

Systems were in place to safeguard people. Staff were suitably recruited and the required pre- employment checks were completed before they commenced work at the service. Staff were trained in safeguarding and were aware of their responsibilities to report poor practice. Guidance on how to respond to safeguarding concerns were displayed on notice boards throughout the home. A relative told us they felt there was a delay in appropriate action being taken in response to a safeguarding incident concerning their family member. This was fed back to the provider. They confirmed the relative had previously complimented them on the way the incident was managed. The registered manager agreed to explore it further with the relative.

People's care plans contained risk assessments in relation to the management of risks for them. These included risks associated with epilepsy, behaviours, medical conditions and life skills. In one file the risk of choking and the risk associated with a shunt (a medical device that relieves pressure on the brain caused by fluid accumulation) were not easily accessible and available to staff. The registered manager agreed to address this so that high risks for individuals were highlighted and the guidance around the management of those would be made more accessible, particularly as the service used a high number of agency staff. Staff were aware of their responsibility to act on and report accident and incidents. Accidents and incident records were maintained and monitored through monthly reporting to the organisation.

Systems were in place to promote a safe environment. People had individual personal emergency evacuation plan (PEEPs) in place. These outlined how individuals should be supported to evacuate the building in the event of a fire. In house health and safety checks and fire drills took place. Equipment such as fire, electric and moving and handling equipment was serviced and fit for purpose. An environmental risk assessment and fire risk assessment was in place which identified risks to people, staff and visitors. We saw that a Legionella check was overdue. After the inspection the registered manager sent us confirmation that a Legionella check was carried out in August 2018.

The staffing levels varied across the units and were dependant on people's needs and the level of supervision required. The service had a number of people on one-to-one care. This was recorded on the shift planner and staff allocated to individuals. The home had 20 full time staff vacancies. The provider was actively looking to recruit into the vacancies. Bank and agency staff were used to cover gaps in the rota. Due to the high staff vacancy levels a number of bank and agency staff were used on each shift. A minimum of two nurses were provided on the day and night shifts. Staff told us the required staffing levels were maintained and the staffing levels were sufficient. Rotas we viewed reflected that. Relatives were complimentary of the permanent staff but they felt some agency staff "sat around", which put a lot of pressure on the permanent staff. The registered manager was addressing that through the use of regular agency staff and not using agency staff for whom issues were identified about their standard of work and involvement on shift.

Systems were in place to promote safe medicine administration. People's care plans outlined the support they required with medicines. A medicine policy was in place to guide staff on the practice. One person was supported to self-administer their medicine. Medicines were safely managed, administered and stored in line with pharmaceutical guidance. Daily stock checks of medicines took place before and after medicines were administered. This enabled staff to pick up any discrepancies in medicines in a timely manner.

The home was generally clean. Cleaning staff were employed and care staff also completed cleaning tasks daily. The service had a designated infection control champion. Notices were displayed in the home to guide staff and others to them in the event of any infection control queries. Each person had an infection control risk assessment and quarterly infection control audits took place.

Good

Is the service effective?

Our findings

People continued to receive effective care.

People were assessed prior to them coming to live at the service. The assessment identified people's cultural and diverse needs. Prior to each respite stay families were asked to update the service on any changes for their family member since the last stay. This was reviewed on the day of admission and enabled the service to identify and manage any new risks, changes in medicines and medical conditions.

Relatives told us they believed the permanent staff had the required training and skills. A relative commented, "There are plenty of well trained staff supporting, with new staff being trained up all the time."

Staff told us they had received a comprehensive induction which included face-to-face training and working alongside existing experienced staff. The Care Certificate induction is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles. This had recently commenced and was in progress. All staff were trained in subjects the provider considered mandatory such as epilepsy awareness, equality and diversity and infection control. Alongside this, staff and the registered nurses had access to specialist training and workshops suitable to their roles such as autism, diabetes, management of percutaneous endoscopic gastrostomy (PEG feeds) and medicine management. A training matrix was in place which showed training that had taken place and highlighted when updates were due. The service had recently commenced training regular agency staff used in the service on topics such as epilepsy awareness, safeguarding and promoting dignity.

A health professional involved with the service commented, "We are concerned there are varying levels of skill, interest and motivation to learn amongst the nursing staff." They confirmed they had spoken with the epilepsy specialist nurse and the manager regarding some training needs identified within the nursing staff, but they were unaware if any training was sourced to address these areas. The registered manager was made aware of the feedback to follow up on the specifics of the training required.

Staff told us they felt supported and received regular one-to-one supervision. Records viewed showed regular one-to-one meetings, probation reviews and annual appraisals took place. Supervision of regular agency staff had commenced.

People's care plans outlined the support required with their health needs. They had a hospital 'passport' and an emergency grab sheet in place, to be taken to hospital with the person in the event of an admission there. One relative told us that during a recent hospital admission for their family member, staff had not communicated with the hospital the medicine their family member was on. The registered manager advised this was not the case and agreed to follow it up with the relative.

People had access to a range of health professionals such as the GP, consultant, community nurses and on-site therapy including physiotherapists, speech and language therapists. Records were maintained of appointments with professionals, the outcome and actions required. A first line nurse service was run and

managed from the service. This enabled people in the service and in other locations on site to have access to nursing advice in a timely manner. They liaised with the GP surgeries and pharmacy, as required, to promote people's health and well-being. Relatives told us the service was proactive in seeking medical advice. A relative told us there had been a reduction in hospital admissions for their family member. This they felt was because staff were alert to any changes in their family member's health. One relative told us the service had not contacted the out of hours doctor for their family member, until this was requested by them. This resulted in their family member being admitted to hospital and requiring surgery. The response from the provider suggested medical advice was sought but they agreed to treat the feedback as a complaint and commenced an investigation.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff were trained and were knowledgeable in the Mental Capacity Act 2005 and DoLS. People's care plans identified if people had capacity to make decisions on their care and best interest meetings took place when required. The decision agreed was recorded, for example in relation to people's covert medicines. We saw for some people who lacked capacity to agree to a blood test a mental capacity assessment and best interest meeting had not taken place prior to the procedure. The registered manager had identified this and was working to address it moving forwards. Records were maintained of DoLS applications made and approved.

People's care plans outlined the support required with their meals and nutritional risks were identified and managed. Each person had a food and fluid chart in place. Staff were responsible for cooking the meals. People were involved in menu planning and were encouraged to make daily choices on what they wanted to eat. The meals provided were appetising and enjoyed by people. People who required it were provided with support and equipment with their meal. Relatives were mostly happy with the meals provided. A relative commented, "Staff are now providing good standard of meals. They are happy to cater for individual likes and dislikes, as well as health needs." One relative felt the quality of the meals varied and felt the service could do with a cook.

People were provided with equipment to promote their safety and independence such as sensor alarms and helmets. Each unit was nicely decorated and personalised to the people living there. Areas of the home needed redecoration. A refurbishment plan was in place to address that. A relative told us improvements could be made to the external appearance of the building by removing broken garden furniture and clearing the weeds. This was fed back to the registered manager to action.

Good

Is the service caring?

Our findings

People continued to receive a caring service.

Relatives told us the permanent staff were kind, caring and worked well as a team. They described staff as, "Wonderful, attentive, caring, welcoming, excellent, appropriately affectionate, friendly and knew how to communicate with people who have limited or no verbal communication." Relatives felt the agency staff were less engaging. The registered manager was aware of that and addressing it through putting the agency staff on training or not using agency staff that they got complaints about.

A relative commented, "Care is friendly, person centred with maximum choice given. All carers seem to be on good terms with [family member's name] and it doesn't seem to matter who is on duty as they get on with them all. I have not found a carer that [family member's name] doesn't like."

A health professional told us people and all stakeholders were treated with dignity and respect. A professional commented, "The staff who have come with the patient when the family members have not been able to attend have always been responsible, caring and safe when it comes to the patient and have always brought the patient to any appointments made."

We observed permanent staff had positive relationships with people. They engaged appropriately with people and used good eye contact and appropriate touch. They promoted a relaxed and fun environment for people. We observed a person was supported with their meal. This was done in a supportive and encouraging way. The staff member stood up to support the person due to the design of the person's chair. The registered manager agreed to look into getting an adjustable chair for staff to enable them to sit down but be at the right level to still support the person safely.

Some agency staff demonstrated positive interactions with people, whilst other agency staff were observed sitting in the lounge but not engaging with people. An agency worker was heard telling a person who was distressed to "stop it." These observations were fed back to the registered manager to address.

People's care plans outlined their communication needs. We observed people were supported to make day-to-day decisions on their care through the use of pictures, gestures and by staff being aware of people's responses to a question. Information relevant to people for example activities, fire safety and safeguarding was provided in easy-read and picture format. These were displayed on notice boards throughout the home.

People had their own bedrooms and ensuite shower. The bedrooms we viewed were personalised and reflective of individuals interests. Staff were observed to be respectful of people's privacy and dignity. They knocked on people's bedroom doors and sought permission to go into their bedroom if the person wasn't there.

The service had named staff who were dignity and communication champions. Staff were being trained in those roles to further develop communication for people and consistently promote people's dignity.

Good

Is the service responsive?

Our findings

People continued to receive a responsive service.

Relatives felt the service was responsive to their family member's needs. A relative commented, "The permanent staff know [family member's name] well and know when something isn't right and take action."

People had person-centred care plans in place. They provided clear guidance on the support people needed with aspects of their care such as personal care, medical needs, life skills and activities. Positive behaviour plans were in place for people who required it and each person had an epilepsy protocol in place. Pictorial guidance was provided for the management of wounds and artificial feeds. Care plans were regularly reviewed but all the reviews stated, "No change." This was fed back to the registered manager to consider how the reviews of care plans could be developed.

People had a named keyworker. Relatives were aware who their family members keyworker was and had positive relationships with them. One relative commented, "[Staff member's name] is excellent, we have a very good relationship and she cares for my family member really well." People had reviews with the funders of their care. The frequency of people's reviews varied. Relatives told us the reviews took place and they contributed and were involved in them. One relative could not recall a review for their relative. This was fed back to the registered manager to explore.

A professional told us they had good communication with some of the senior key workers. They commented, "They have been excellent in formulating a plan with me and the patient's family to ensure the foot health treatment plan is followed and consistent and are happy to adapt it when it needs to be." Another professional told us two of the units had a relatively consistent support team, which enabled a higher degree of person-centred care. They commented, "The team know their residents well and are motivated to enrich the lives of those residents." They told us the other two units were less engaging with them. This was fed back to the registered manager to review and act on.

People had an individual pictorial programme of activities. Activities were supported and promoted during the inspection. Relatives were generally happy with the activities provided. A relative told us how their family member had gone skiing and to an air show, which was a huge achievement for them. Some relatives thought people spent a lot of time watching television. A relative felt a simple activity like taking their family member out in their wheelchair could enhance their life. Other relatives told us the lack of transport and regular staff impacted on activities that took place. The registered manager told us activities were under review and those issues would be addressed.

People and their relatives had access to the complaints procedure, which was available in a pictorial format. Relatives knew how to raise concerns and complaints and confirmed issues raised had been addressed. One relative told us they felt the service learned from complaints and put measures in place to prevent recurrence of the same issues. A record was maintained of complaints received and action taken. Since January 2018 the service had received four complaints and ten compliments.

The service had no one on end of life care at the time of the inspection. People's care plans showed evidence of discussion with family members around end of life care and funeral plans. A relative told us they had been involved in a discussion about their family member dying. They told us they valued that discussion being facilitated in advance.

Good

Is the service well-led?

Our findings

People continued to receive a well-led service.

The service had a registered manager. They were aware of their responsibilities to make notifications to us and under the duty of candour to be open and transparent when things go wrong.

Relatives felt the service was well managed. They described the registered manager as professional, knowledgeable, excellent, approachable, accessible, always willing to listen and felt things were dealt with efficiently and humanly as possible. They commented, "The registered manager is very good, capable, has a good overview, receptive to feedback and acts on concerns. They provide a superb service." Others said, "The manager runs a happy, friendly environment with complete medical supervision. This is a home where all are welcome", The manager is approachable if needed and knows the people as individuals. It doesn't matter who is on duty things are the same, a sign of good management. Staff and residents are happy." One relative was dissatisfied with aspects of the management of the service. This was fed back to the provider who agreed to investigate the concerns and liaise with the family member.

Staff were happy with the way the service was managed. They described the registered manager as approachable, accessible, good listener, caring, understanding and involved in the service. Staff commented, "A positive role model who shares their knowledge and experience", "I feel respected by management, listened to and valued which promotes team working. Things are well organised and problems and challenges are dealt with", "The manager is fair but firm with all of us and is quick to monitor issues so that they can be dealt with swiftly. We are a very busy service with many facets to it; something that is not always appreciated higher up the ladder and the manager is managing all these different areas well."

The registered manager was clear of their vision for the service. Their priority was to recruit to the vacancies and was looking at innovative ways of doing that. They were keen to develop the respite service and had a proposal in place to set up a radio station at the site which would benefit the people living there, relatives and staff.

People's records were kept secure, however they were cumbersome and information was not easily accessible. We found gaps in health and safety checks, a medicine record was not updated to reflect that medicine was to be administered via a feeding tube, medicine competency assessments were not tracked and therefore there was no overview of which staff had been assessed to safely administer medicines. After the inspection the registered manager sent us evidence to indicate action was taken to address those shortfalls.

Systems were in place to audit the service. The provider carried out monitoring visits and the reports highlighted any areas for improvement. The service carried out a series of audits such as care plans, infection control, health and safety and catering. Actions arising from the audits were not routinely completed. Where action plans were completed they were not followed- up on or signed off as completed. The home had a continuous improvement plan but the actions from the internal audits were not transferred

to that. This had the potential for areas for improvements not to be acted on. After the inspection the registered manager sent us an action plan outlining how records and audits would be improved and when. We were satisfied with the contents of the action plan and the assurances given by the provider to make the required improvements to records and audits.

People, staff and relatives were given the opportunity to provide feedback on the service. Regular staff and clinical review meetings took place. People, staff, relatives and stakeholders completed annual surveys about the service and families were invited to relative meetings. A relative commented, "Yes, there are regular surveys of the service to give feedback; there are quarterly family and friends meetings. The manager and the team have an open approach to feedback and we always try and give this, good or not so good, in the moment."

A professional commented, "The nurse-led clinical review meetings, which I attend, are working well. My impression is the actions regarding residents' support and care, which are identified during these meetings, are acted upon in a timely fashion; however, meetings do not include a review of the actions identified in the previous month's meeting." The registered manager was made aware to address this issue with the staff team.