

Royal Hospital Chelsea

Margaret Thatcher Infirmary

Inspection report

Royal Hospital Road
Chelsea
London
SW3 4SR

Date of inspection visit:
21 September 2016
22 September 2016
23 September 2016

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Ratings

Overall rating for this service

Outstanding 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Outstanding 

Is the service responsive?

Outstanding 

Is the service well-led?

Outstanding 

Summary of findings

Overall summary

This inspection took place on 21, 22 and 23 September 2016 and was unannounced on the first day. We told the registered manager we would be returning over the next few days. At our previous inspection on 29 May 2013 we found the provider was meeting the regulations we inspected.

The Margaret Thatcher Infirmary provides accommodation for up to 100 people who require nursing or personal care. At the time of our inspection 81 people were living in the infirmary. The organisation also provided personal care to approximately 20 people who were living in the Royal Hospital Chelsea, known as the long wards. This was through their domiciliary care service. People who use the service are known as 'pensioners' and they usually move into the Royal Hospital Chelsea onto the long wards. Pensioners could then progress to the four wards within the infirmary if they are assessed to need more care due to frailty and healthcare needs.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People told us staff were kind and compassionate and knew how to provide the care and support they required. Staff were committed and motivated, and understood the importance of getting to know people and understand their personal histories. All staff showed concern for people's health and welfare in a caring manner, with enough time given for positive relationships to be developed.

People were spoken with and treated in a respectful and kind way and staff respected their privacy and dignity, and promoted their independence. People also had the support of Captains of Invalids, who were responsible for people's social welfare and well-being. People felt comfortable speaking with them due to their military background. Where appropriate, people and their families were involved in decisions about end of life care and staff were aware of the importance of respecting people's wishes and providing support at this sensitive time. Care for people at this stage of their life had been recognised as outstanding.

People had direct access to healthcare services as there was an on-site GP and physiotherapist, with regular visits from other healthcare professionals, such as occupational therapists, chiropodists, audiologists and speech and language therapists. We saw if staff had any concerns about people's health, immediate referrals were made with appropriate follow up meetings.

People were supported to follow their interests and were encouraged to take part in a comprehensive range of activities and programmes to increase their well-being and reduce social isolation. There were a number of events held within the service along with day trips, including opportunities to travel overseas. The provider also had the use of volunteers to support people with activities and events. People were able to be ambassadors of the Chelsea Pensioners, and supported to represent them at official events throughout the

world.

There was a real sense of a unique community spirit throughout the service with all the amenities, public gardens, tours and a museum that people could volunteer in that was open to the general public. The provider's values were embedded throughout the service and understood by all.

People were involved in planning how they were cared for and supported. An initial assessment was completed from which detailed care plans and risk assessments were developed. Care records were person centred and developed to meet people's individual needs and reviewed if there were any significant changes. People and their relatives were actively encouraged to express their views and were involved in making decisions about their care and whether any changes could be made to the support they received.

People knew how to make a complaint and were able to share their views and opinions about the service they received. The provider listened to all complaints and made sure people were confident their complaints would be taken seriously. When issues were highlighted we saw action was taken. There were also surveys in place to allow people and their relatives the opportunity to feedback about the care and treatment they received.

There were effective quality assurance systems in place to monitor the quality of the service provided and understand the experiences of people who used the service. The registered manager followed a regular cycle of quality assurance activities and learning took place from the result of the audits. Quality assurance processes included obtaining and acting on the views of people in order that their views could be used to drive improvements throughout the service.

The service promoted an open and honest culture and the registered manager and senior staff team were transparent in their discussions with us during the inspection. The registered provider focussed on their core values and staff were dedicated and knew what was expected of them, feeling privileged to be able to care for people who had served in the British Army.

Staff spoke highly of the support they received from management and were confident they could raise any issues or concerns, knowing they would be listened to and acted upon. The strength of leadership throughout the service contributed to the outstanding level of care, attitude of staff and quality of life for people using the service.

Staff were aware of people's dietary needs and food preferences and provided support to those who required it during mealtimes. There was a good variety of choice available and people had the opportunity to feedback about the food they received. People also had the choice to visit the on-site café or licensed bar.

There was a comprehensive induction and a 12 month probation period for new staff. Staff members also took part in a training programme to support them in meeting people's needs effectively. New staff shadowed more experienced staff before they started to deliver personal care independently and received regular supervision from management. They told us they felt supported and were listened to during the supervision they received.

People who required support with their medicines received them safely from staff who had completed in-depth training in the safe handling and administration of medicines, which was refreshed annually. Staff training in this area included observations of their practice to ensure medicines were given appropriately and with consideration for the person concerned. Staff completed appropriate records when they

administered medicines and these were checked after each medicines round on the same day to minimise medicines errors. More thorough checks were carried out on a monthly basis and findings were discussed at quarterly governance meetings.

The service had a robust recruitment process and staff had the necessary checks to ensure they were suitable to work with people using the service. Sufficient numbers of staff were employed to keep people safe and meet their needs, being able to spend enough time with them to know them well.

Staff demonstrated a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff were aware of the importance of asking people for consent and the need to have best interests meetings in relation to decisions where people did not have the capacity to consent. The provider was aware when people had restrictions placed upon them and notified the local authority responsible for assessment and application.

There were robust systems and processes in place to protect people from the risk of harm. Staff were aware of different types of abuse, what constituted poor practice and the correct action to take if abuse was suspected. Appropriate safety checks of the building, equipment and maintenance systems were undertaken to ensure health and safety for people and staff was maintained.

People's risks were managed and care plans contained appropriate and detailed risk assessments which were updated regularly when people's needs changed. We saw accidents and incidents were closely monitored by the registered provider and discussed at quarterly meetings.

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 received their medicines safely. Medicines were administered and recorded by staff who had received relevant medicines training which was refreshed annually.

Detailed risk assessments were in place to identify the areas of risk and to reduce the likelihood of people coming to harm. They were routinely reviewed and additional reviews were conducted if any significant changes occurred.

The provider took appropriate steps to ensure robust staff recruitment procedures were followed and there were sufficient staff to meet people's needs.

Staff had a good understanding of how to recognise and report any signs of abuse and protect people from harm.

Is the service effective?

Good ●

The service was effective.

Staff were aware of people's health and well-being and responded quickly if their needs changed. People had direct access to a GP and other health and social care professionals, such as occupational therapists, physiotherapists and speech and language therapists.

People received care and support that met their needs and reflected their individual choices and preferences. Staff received the training and supervision they needed to meet people's needs and were passionate about their jobs.

Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were supported to have a balanced diet, with plenty of choice, which took into account their preferences as well as their medical needs.

Is the service caring?

Outstanding ☆

The service was outstandingly caring.

We saw that staff treated people with respect and kindness, and promoted their dignity and independence. People told us staff were incredibly kind and compassionate which had a positive impact on their lives.

People, and their relatives where applicable, were informed about their health and well-being and were actively involved in decisions about their care and support, in accordance with people's own wishes.

The service supported people's social welfare and each person had a designated contact to meet with on a weekly basis. They also supported people and their families during end of life care, receiving recognition for best practice in this area.

Is the service responsive?

The service was outstandingly responsive.

There was a comprehensive list of activities, trips and events available to people, with facilities including a gym, coffee shop, a chapel and a licenced bar.

Care records were detailed and personalised to meet people's individual needs so staff knew how people liked to be supported. The information was easily accessible for staff and updated if there were any significant changes.

People and their relatives knew how to make complaints and said they would feel comfortable doing so. The provider gave people and relatives the opportunity to give feedback about the care and treatment they received and acted on this promptly.

Outstanding 

Is the service well-led?

The service was outstandingly well-led.

People and their relatives told us that the service was extremely well managed and the registered manager was dedicated in their role, having a visible presence throughout the service.

Staff spoke highly of the management team and felt they were supported to carry out their responsibilities.

There was a comprehensive programme of audits and meetings to monitor the quality of the service and identify any concerns. Any concerns identified were documented, discussed and acted

Outstanding 

upon to improve the lives of people living in the service.

Margaret Thatcher 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.

The inspection took place on the 21, 22 and 23 September 2016 and the first day of the inspection was unannounced. We told the registered manager that we would be coming back over the next few days.

The inspection team consisted of three inspectors, a specialist professional advisor who was a GP and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert by experience had experience in the care and support of older people who use regulated services, including people experiencing the onset of dementia.

Before the inspection we reviewed the information the Care Quality Commission (CQC) held about the service. This included statutory notifications of significant incidents reported to the CQC and the report for the last inspection that took place on 29 May 2013, which showed the service was meeting all the regulations that we checked during the inspection. The provider also submitted a provider information return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 29 people using the service, one relative and 22 staff members. This included the director, the registered manager (also known as the matron), three senior staff nurses, one care team manager, three senior care assistants, three care assistants, a human resources (HR) assistant, an activities coordinator, two chefs, two Captains of Invalids, the chaplain and one security guard. We also spoke with the registered GP and receptionist in the medical centre. We looked at 13 people's care plans, nine staff recruitment files, staff training files, staff supervision records and audits and records related to the management of the service.

Some people living at the service were not fully able to tell us their views and experiences so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us

understand the experience of people who could not talk with us. We carried out these observations during different parts of the day during the inspection.

Following the inspection we spoke with two health and social care professionals who had worked with people using the service for their views

Is the service safe?

Our findings

People we spoke with told us they felt safe living in their home and when they were receiving their care. Comments included, "The staff are great here and I do feel safe. I don't feel scared or intimidated", "It's excellent. I feel safe here as there are enough staff and I have two alarms. There is always somebody here", "Safe as houses, there's no reason to be unsafe here" and "There is always somebody here to help me out and can deal with any request. It was the best thing I ever did in coming here." The relative we spoke with had no concerns about the safety of their family member. They added, "It is very good, they look after [my family member] very well."

People's medicines were managed safely. We observed medicines being administered over two days of the inspection. The nurses administering the medicines were observed to check with each person and follow accurately each step of the administration process. People confirmed that their individual requirements were met. One person said, "They give it to me at the right time of day and are in charge of that for me." Another person said, "The nurses give me my medicines in a timely manner in the morning and evening. It works quite well."

We checked how the service stored medicines, including controlled drugs and the safe disposal of medicines no longer required. Each of the four wards had a nursing station, with medicines stored where a key code was required for access. The temperatures of the rooms were controlled by air conditioning and the medicines fridges were checked and also recorded on a daily chart. Random checks of several medicines including controlled drugs were carried out and we found that the quantity in stock matched the records in the controlled drugs register. The administration of controlled drugs was carried out and signed by two nurses, which provided additional assurance that people were receiving these medicines as prescribed. We looked at a sample of medicine administration record (MAR) charts over two wards during this inspection. All MAR charts had the person's allergy status recorded and a recent picture of the person, which was renewed yearly, to assist staff in identifying the correct person during medicines administration. We also looked at one MAR chart for a person receiving the domiciliary care service who needed support in applying topical creams. There were no gaps on the MAR charts that we looked at and there were records to explain why any doses of medicines had not been administered.

MAR chart audits were completed on a daily basis by staff involved in medicines administration and senior nursing staff completed monthly medicines audits to check that medicines were being managed safely. We saw evidence that the audits picked up medicines issues appropriately, where the internal audit showed a low error rate of only 0.4%. One senior care assistant told us how important it was to educate staff about the importance of documenting errors. They added, "We want to retrain people, not punish them." We saw records that showed where errors occurred, they were reported, investigated and staff members involved were retrained and had supervision. This helped to ensure that staff learned from mistakes to reduce the likelihood of a reoccurrence and avoidable harm to people using the service.

Appropriate checks were carried out before staff began work. The nine staff files that we looked through were consistent and showed that the provider had robust recruitment procedures in place to help safeguard

people. We saw evidence of photographic proof of identity and Disclosure and Barring Service (DBS) records for staff were available. The Human Resources team were aware of when they needed to be renewed in line with the provider's policy and a DBS matrix was in place, with alerts set up for staff to contact employees when they were due to be renewed. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working in care services. There was also evidence that the personal identification numbers of registered nurses were in date and the provider carried out monthly checks to ensure they were aware of the registration status of their nursing staff. The provider requested three references and people could not start work until two had been received and verified. We saw records that showed the provider followed up any gaps in past employment history.

The Human Resources assistant told us that to help check for staff suitability, they held an open morning where prospective applicants would be invited and were observed on their interaction with people and discussed the provider's core values. At the interview applicants had to record their experiences of teamwork, care of older people and their understanding about responsibilities regarding reporting abuse and poor care practice, which was scored by the interview panel and signed off. This helped to ensure that people were supported by staff who were suitable for their roles.

People told us that staffing levels were sufficient to meet their needs. One person said, "Call bells are answered very quickly, they don't take long at all." At the time of the inspection there were 86 members of staff employed to work at the service, many of whom had worked for the provider for a number of years. Of these, 17 were registered general nurses, with one being a registered mental health nurse. The staffing numbers on the floors we observed were noted to be consistent and adequate for the care provided. We reviewed rotas for one week in each of the past three months over two wards and found the staffing levels were consistent with those as described by the registered manager and the staff we spoke with, and in some cases had exceeded this. A senior staff nurse was also employed as managerial cover at night and handed over with the morning staff on each ward. The registered manager and director were also registered nurses and would be able to support the staff team if necessary.

Staff had received appropriate training in safeguarding and were able to demonstrate how to keep people safe from the risk of abuse. Staff understood how to recognise the signs of abuse and told us they would speak to the registered manager or senior staff if they had concerns about a person's safety and/or welfare. Staff were aware that they could also contact other appropriate organisations with any concerns but felt confident any concerns raised would be dealt with by the provider. One senior care assistant said, "I was really pleased with how a concern I reported was dealt with, along with the outcome of it. It makes us confident in reporting issues." The senior staff nurse responsible for training showed us records of all the safeguarding training and it was refreshed on an annual basis. We saw safeguarding posters throughout the wards with the reporting procedures displayed within the ward offices. Safeguarding issues were discussed regularly through weekly welfare meetings and quarterly clinical governance oversight committee meetings.

Systems were in place to protect people from avoidable harm. There was a procedure to identify and manage risks associated with people's care. Before people started using the service an initial assessment of their care needs was carried out by the registered manager or another senior member of staff, which identified any potential risks. A range of risk assessments were completed in relation to the environment, people's mobility, cognition, behaviour, medicines and personal care support needs. Dependency assessments were carried out on a monthly basis covering areas including nutrition and individual support with feeding, continence care and skin integrity. The care plan contained details about the level of support that was required and detailed information about people's health conditions. The information in these documents included practical guidance for staff in how to manage risks to people. Nurses and care

assistants knew about individual risks to people's health and well-being and how these were to be managed. Records confirmed that risk assessments had been completed on a monthly basis and care was planned to take into account and minimise risk to keep people safe.

For example, we saw one person who had lost 10 kilograms over a month period. We saw that a food and fluid chart had been started and they had been referred to the dietitian. Staff we spoke with were aware of the risk and knew in detail the advice that had been given. We saw that the person was weighed on a weekly basis and their Malnutrition Universal Screening Tool (MUST) score was reviewed on a weekly basis. Another person had been frequently leaving the service and on occasions had stayed out all night. Staff had considered the risks and balanced this with the person's right to make choices for themselves. There was a detailed missing person procedure within their file which had been updated when their health needs had changed. There were risk assessments in place for dealing with behaviour that challenged the service, with detailed information about possible triggers and actions staff could take to prevent this.

There was an infection control policy in place and staff were aware of the importance of wearing personal protective equipment when carrying out personal care and serving people food to minimise the risk of possible infection within the building. Information from the most recent survey highlighted that people were happy with the domestic staff and the cleaning of the premises. Each ward had a clinical audit every six months which covered infection control procedures, covering hand hygiene environment, disposal of waste, laundry and spillage of fluids, with actions clearly stating who was responsible and when they were to be completed.

Is the service effective?

Our findings

People told us they were happy with the care they received from staff and felt they had the right skills and experience to meet their needs. Comments included, "The staff here are brilliant, I am very well looked after", "I get good care and support. Being here helps me to keep my independence", "Everybody does the best they can. The doctor and staff are brilliant, we are very lucky" and "Some staff are extremely good, and others are always learning. As long as they are learning it is working OK." One relative told us they were very happy with the staff that cared for their family member and felt very reassured they had direct access to the GP. They added, "My [family member] gets regular checks throughout the day, we are very happy." One health and social care professional commented how motivated the staff were and open to learning, asking for advice and support when required.

All the staff we spoke with said they supported people to manage their health and well-being and would always speak with the registered manager or senior staff nurses if they had any concerns about the person's healthcare needs. People spoke positively about the medical centre and the access they had to their GP. The medical centre was headed by a GP who was employed by the Infirmary and lived on site. He worked 10 sessions a week and was supported by a part-time GP who did a morning session on Mondays and worked all day on Fridays. A urologist visited the medical centre once a month and an audiologist saw patients at the centre on a fortnightly basis. The centre also employed a practice nurse, a health care assistant and a receptionist. On a typical day up to 15 people were seen in a morning session and around 10 in an afternoon session. In the time after morning and afternoon sessions the GP visited patients on the wards in the Infirmary and did "home visits" to pensioners in the long wards. We could see that most people, if not all, were able to be seen on the same day. There was an out-of-hours GP service that covered the medical centre after 6.30pm on weekdays as well as over weekends. The GP was very positive about his experience and said that the way medicine was practiced at the centre was really good as they had time to see people properly. They added: "I love working here. This is general practice at its best."

We saw information in people's care records where staff had made contact with a number of health and social care professionals, including occupational therapists, physiotherapists, speech and language therapists (SALT) and dietitians. They were involved in multi-disciplinary team meetings which were held on a fortnightly basis to discuss people's health concerns. There was a monthly diabetic clinic available and people had access to chiropodists every two months. Each ward had a weekly planner which highlighted what healthcare appointments people had, and who would escort them. This would either be the provider's own ambulance, hospital transport, staff, relatives or volunteers. One person said, "The chiropodists here are very good, she has her own room. She's a lovely person and she knows her job. To go to the optician and dentist we go in our ambulance with an escort." Another person said, "I have to go to a clinic every month and the staff come with me. It's very efficient."

The service had monthly health awareness programmes, such as stroke awareness, asthma and stop smoking. They had a stop smoking campaign called 'Kick It', with weekly clinics. We saw a photo of one person who had successfully stopped smoking and had received a certificate. The provider also had 'Coordinate My Care' in place, an electronic record accessed by GPs, community nurses, out of hours'

specialists and the London Ambulance Service. This meant that people's medical history, including resuscitation status and advanced directives were known by relevant professionals in order to ensure that they received medical support in line with their stipulated wishes.

When staff started their employment they had a four week induction programme which covered mandatory training and a variety of morning, evening and overnight shifts to get a good overview of the running of the service. Staff were expected to complete The Care Certificate as the main part of their induction programme. The Care Certificate sets the standard for the fundamental skills and knowledge expected from staff within a care environment. Four senior members of staff had completed training to be assessors, with three members of staff waiting to complete it. Staff confirmed that they had completed an induction programme at the beginning of their employment that had included the opportunity to shadow more experienced staff until they felt confident. One care team manager told us how they observed a medicines round for two weeks during their induction, which helped them to learn the routine and boost their confidence. Staff also had the opportunity to sign up for vocational qualifications in health and social care. These are work based awards that are achieved through assessment and training. To achieve these qualifications, candidates must prove that they have the ability and knowledge to carry out their job to the required standard. Staff had a 12 month probation period and had a review every 10 weeks. We saw records in the staff files that showed their conduct, punctuality, efficiency, attendance and health were discussed and then confirmed if their probation period had been successfully completed.

There was a comprehensive training programme that was delivered to staff as part of the mandatory induction. Modules included safeguarding, moving and handling, fire safety, Mental Capacity Act 2005 (MCA), medicines, infection control and customer service, which were refreshed on a yearly basis. A senior staff nurse showed us their staff training matrix which covered all modules and identified when training had been completed. We saw that staff also received training which was specific to people's individual needs and that staff had completed training in a range of areas, including oral health, recognising pain, dementia awareness, falls awareness, continence care, sensory loss and pressure sore awareness. Staff we spoke with throughout the inspection spoke highly of the training available to them and how it improved their understanding of their role. One senior care assistant told us about a pressure sore awareness training course that took place on the first day of the inspection. They said, "The training is very good, it keeps our attention and is very relevant. The tissue viability training was really interesting." Staff who were responsible for administering people's medicines had regular training and completed annual competency assessments. A care team manager said, "The medicines training was very in depth and then we observed a round, had a competency test and then we were supervised giving medicines. It is really good that we get to put into practice what we have learnt."

We saw records that showed staff had regular supervision and an annual appraisal system was in place. We looked at a sample of records of supervision sessions which showed staff were able to discuss key areas of their employment. We saw that they were detailed and individualised. Items discussed included recent issues involving people they supported, learning and development, work place matters and actions from previous meetings. One care team manager told us they were able to discuss concerns they had recently with a person who displayed behaviour that challenged the service, and how they discussed techniques to work more effectively with that person. A care assistant said, "We are able to bring up issues and concerns with how things are done, or any staff issues". Staff also had yearly appraisals in place. We saw a sample of records which showed the meetings discussed the staff member's aspirations and performance and whether objectives had been met and specific tasks completed.

Staff understood the main principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so

for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS).

The registered manager and senior staff team demonstrated a good understanding of the process to follow where it was thought that people did not have the mental capacity required to make certain decisions. We saw records that showed best interests meetings had taken place and when mental capacity assessments had been completed. We saw DoLS applications for people who were under constant supervision and not free to leave the building for their own safety. We saw records of extensive involvement with health care professionals when staff had concerns about people's capacity, involving the Community Mental Health Team (CMHT), dementia specialists, Independent Mental Capacity Advocates (IMCA) and best interests' assessors. The application and authorisation documents we saw were kept in people's files, were in date and in good order and reflected in people's care plans. There were well designed forms in place for assessing people's capacity and recording advanced directives, such as where people would want to reside if their health deteriorated or whether they would prefer to be buried or cremated.

Staff told us they always asked for people's consent prior to providing personal care for them or carrying out any care tasks. One care assistant showed us a pocket sized guide they carried around with them about the five principles of the MCA and was able to explain their understanding in detail. We saw people's care records and consent forms had been signed by people to say they agreed to the care being delivered. Where we saw one care record that had not been fully completed, staff explained that they were waiting for the person to be assessed as part of their DoLS application, and had involved relevant healthcare professionals.

We observed lunch over the four wards during our inspection, including use of the Short Observational Framework for Inspection (SOFI) on Campbell ward, which was for people living with dementia. We saw in some wards that chairs were labelled with the person's name if this was their preferred place to sit and/or if they had specialist cushions in place. Most people were sitting in places of their choice in the dining room. Where needed, staff helped people to their seats and asked them where they wanted to sit. People could also have lunch in their room if they wanted to. Two people were sat in bariatric chairs and were supported individually by staff, who assisted them with their meal patiently and at their own pace. Bariatric chairs are specially designed to offer comfort, rise and recline support to people who have reduced mobility. Staff provided reassurance through speaking with them and stroking their arms, including preserving their dignity by ensuring their faces were kept clean. Everyone had drinks of their choice available, including wine. People could choose the size of serving for their soup, with four choices for the main meal, a selection of sides and four choices for dessert. Staff explained the options available and in the event they did not eat their food, staff provided reassurance and encouraged people to eat alternative choices. The service was not rushed and people who required support from staff received it in a caring manner, with a very relaxed and chatty atmosphere between people and staff.

Observations from our SOFI showed the general ambience was relaxed and peaceful, with lots of positive interactions. When people displayed behaviours that challenged the service, the level of staffing and evident skills of staff in relation to communicating with people meant that people functioned remarkably well for extended periods of the lunch time. Furthermore, when one person became distressed, staff provided comfort and support and were aware of strategies to help the person feel calm.

The service had been awarded a five star food hygiene rating at its most recent inspection. The top rating of five means that the home was found to have 'very good' hygiene standards. People we spoke with complimented the quality of the food provided and told us that they always had a choice of what to eat at every meal. People's dietary needs and preferences were respected and catered for. We spoke with chefs who were aware of people's different food choices and how they catered to meet people's medical and cultural needs. Those with dietary requirements had a personal menu plan. Diabetic and soft diet choices were available, including vegetarian options. There was salad and fresh fruit available every day. One of the chefs told us that they have monthly meetings with people to get feedback about the food. They added, "Meals can be made upon request and it is communicated through the care staff. Comments about the food included, "There are meetings about the food and we get to give feedback. The food is really good" and "I'm diabetic and they cater for me accordingly". People also told us that when they had made complaints about the quality of food, improvements had been made.

Is the service caring?

Our findings

All the people we spoke with told us they were happy with the care they received at the home and spoke positively about the staff who supported them. Comments from people included, "The staff are very helpful and give us lots of tender loving care. If you ask for anything a second later it's delivered. The attitude of the people serving you, they enjoy doing it so you feel part of the family", "The staff are extremely good, very helpful and very caring. They go out of their way to help", "I get on really well with them and we have a laugh and a joke. They know me really well" and "They know me and want to get to know you as a person." A health and social care professional told us that they could tell staff knew people really well and had a great rapport with them, including their family members.

Throughout the inspection we observed positive interactions between people using the service and staff. Staff were always observed to be compassionate and interested in the needs of the people they supported. Whilst observing some activities people were very relaxed and comfortable with staff and we could see that people felt happy to express their wishes and felt comfortable in their presence. During an activity we observed one person who did not wish to participate so the activities coordinator suggested that they referee the game, to which they accepted. This showed that staff were creative in supporting this person to contribute in a manner that appealed to them. In an exercise class, staff encouraged people to be as independent as they wanted to be and offered a variety of choices for carrying out the activity, communicating with them in a friendly and relaxed approach. One person told us that due to health problems, they were sad to be moving onto another ward. The registered manager confirmed with them that they had been assigned a new one to one care assistant to stay with them for the transition period to the new ward, to provide emotional support.

Staff we spoke with knew the people they were working with and were able to give information about people's personal histories. One person said, "You get to know them and they get to know you, it's like a family." Within people's care plans we saw detailed personal information, specifically relating to people's life history, family and time in the military. It also documented personal preferences, interests and achievements, during and after their military service. We overheard many friendly conversations during the inspection, with staff having the time to sit and chat with people. We observed one staff member being very engaged with one person who was talking about their military service and where they had been stationed. The care team manager said it was really important for staff to have the time to spend with people and build positive relationships with them. They told us, "We try to create more interaction opportunities with people and management are supportive of this." We spoke with one person who had moved to the infirmary within the last year due to deteriorating health. They said, "The care couldn't be better. Everybody is a friend and you get a twenty-four hour service. It is idyllic." One care assistant said, "The pensioners are really lovely. We enjoy their stories and enjoy their company."

People using the service confirmed they were involved in making decisions about their care and were able to ask the staff for what they wanted. A senior staff nurse told us when they carried out assessments and reviews they always made sure, where appropriate and with consent, a relative or healthcare professional was present with the person. One person said, "I am always involved and when it was reviewed recently it

was all discussed properly." People were also supported to access advocacy services. Advocates are trained professionals who support, enable and empower people to speak up. This meant that where people did not have the capacity to express their choices and wishes or found it difficult to do so, they had access to independent support to assist them. Staff knew when they needed to involve advocates and worked closely with them. We saw records, where it was appropriate, where people had access to an Independent Mental Capacity Advocate (IMCA).

Apart from people's medical care, there was a significant emphasis on the mental and social welfare of people. There were three 'Captains of Invalids' whose role was to oversee the welfare of 100 people each and to ensure their general all-round wellbeing. Although they were called 'captain', they were in fact more senior in rank. One was a major, one was a lieutenant colonel and one was a colonel. They were military officers who were employed by the provider and lived on site, enabling them to have a visible presence throughout the service. We spoke with two of the captains who told us that they visited each person they were responsible for every week and had a chat to find out how they were. One captain told us how they used the network of staff, including porters and domestic staff to see if they had noticed any concerns with people, as they saw them on a daily basis. Another captain said, "I organise events like coffee mornings, and we send our ambassadors everywhere, which we book and organise." They added, "We represent the people here and it is our job to take any worry off their shoulders. If someone's relative is ill, I'll liaise with the family." As the people using the service were seen as ambassadors, this provided them with an important purpose and helped their self-esteem, as it meant they were still actively serving their community. They were regularly invited to attend events, both nationally and worldwide. One captain told us how they had supported 12 people to take part in the opening ceremony of the London Olympics 2012, as representatives of the Chelsea Pensioners and ambassadors of their country. They said, "It was one of the proudest moments in my entire military history, being able to walk out with the pensioners with the whole world watching."

People spoke very positively about the support they received from their captains and felt comfortable bringing up any issues with them. One person said, "My captain looks after our welfare and we can go to them whenever." A captain explained that they were on call 24/7 to be able to meet the needs of people and would have regular meetings with the medical staff and registered manager if they had any concerns. They added, "We are here to support the staff as people sometimes feel more comfortable talking to us, because of our military background. There is a real feeling of belonging and community spirit here."

People told us staff respected their privacy and dignity and promoted their independence. We heard positive comments about how staff were respectful to people when they worked with them and how people were encouraged to be as independent as possible. Comments included, "Having a little bit of support really helps me to keep my independence. The whole system is great", "They always respect my privacy and dignity, I've never had any unpleasantness" and "They always knock on the door and if you say so, they will go." We observed staff knocking on people's doors and announcing their presence during our visit. People were asked if they wished to speak to us and if they were happy for us to see their rooms. All staff had a good understanding of the need to ensure they respected people's privacy and dignity and we saw this highlighted in people's daily log notes. One care assistant said, "We allow people to take part in their personal care, make use of towels and dressing gowns so people do not feel exposed." A senior care assistant said, "Our aim is to keep people independent for as long as they can. They know that we are trying to keep them as independent as possible."

Staff had a good understanding and were able to explain what the process would be when people were reaching the end of their lives. We saw records that showed each ward had monthly meetings to discuss if people's health was deteriorating, with their life expectancy identified as either years, months, weeks or days

of care. People who had made advanced decisions regarding end of life care had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms in place and this was highlighted in their care plan. All DNACPR paperwork found was well written and demonstrated choice and relatives wishes where appropriate, signed by a GP and staff nurse. People receiving end of life care had a separate care plan, with hourly assessments by nurses for pain, agitation, nausea, vomiting, mouth care and positioning. This helped to ensure that people were supported to maintain their dignity and wellbeing at the end of their life.

We spoke with the senior staff nurse about the training available to support staff with end of life care. They had developed Gold Standards Framework training comprising videos, competency tests and visiting a hospice for further training and experience. The Gold Standards Framework is a framework to help deliver a gold standard of care for all people as they near the end of their lives. It helps staff to identify the needs of people at each stage of their life, assess their needs, wishes and preferences, and to plan care on that basis, enabling them to live and die well with dignity when they choose. We saw the letter from the Gold Standards Framework accreditation board, stating accreditation had been confirmed in August 2015 and was valid for three years. The service had achieved the quality hallmark award at Beacon status, which is the highest accreditation a provider can achieve.

We saw samples of letters that were sent to families or close friends from the Governor of the Royal Hospital Chelsea, which highlighted the late pensioner's achievements, how much they contributed to the community life of the service and how they were understood and valued as individuals. A Captain of Invalid told us that they were able to deliver a full military eulogy at the funeral, to discuss their time in the army and their achievements. We were also shown cards that families had sent when their loved ones had passed away. Comments included, 'Thank you and your excellent staff for the kind care and attention, and for the understanding he/she received' and 'You have been outstanding, thank you so much for your care of my [family member].' In the main reception area there was a remembrance table for people who had passed away, where people were able to write messages of condolence. The registered manager also told us that there was comfortable accommodation available for relatives to stay over during this time. The provider was passionate about ensuring that every person mattered and were valued by everybody at this stage of their life. When people did pass away, the provider made sure they were able to be remembered by loved ones.

There was spiritual support for people and their families when people were coming to the end of life. A resident chaplain was able to spend time with people and their families if they so wished. A senior staff nurse told us that if a pensioner was from a faith that the Infirmary did not have a regular link with then the chaplain would make the necessary calls to contact a representative of the religion to ensure the person's spiritual needs were met.

Is the service responsive?

Our findings

People told us they were happy with their care and support and that they felt involved when decisions were made about their care. Comments included, "I was involved in my care planning and the staff know exactly what to do", "They are very good, everybody does the best they can and I have no complaints", "I am very happy, they look after me well. I sometimes go to the activities and I meet my friends for coffee" and "Everything is reviewed every month, or even sooner if you want it to be." One relative told us that all the staff team knew their family member well and how to care for them. They added, "I am kept up to date, receive letters and know who to call if I need to get in contact." Health and social care professionals we spoke with said that staff were responsive to people's needs and had a good understanding of how to care for them.

We spoke with the registered manager and a care team manager about the process for accepting new referrals into the service. People were invited to visit and were able to stay for four days to see whether they wanted to move in. It gave both the person and staff enough time to see if they liked it and whether they would be able to meet their needs. One relative told us they were encouraged to be present during the visit as guest accommodation is available, as well as the initial assessments. One person told us about their initial visit and how it gave them the opportunity to get to know other pensioners and members of staff. They said, "On my initial assessment, I was able to come and stay for four days to see how I liked it. I couldn't wish for another place." Another person said, "I'm so glad I decided to stay, I wouldn't go anywhere else." When people moved into the service they contributed their army pension towards their living costs but all remaining costs of living at the service were met by the provider. People new to the service had a full and complete pre-admission assessment that included relevant risk assessments, which were comprehensive and informative for staff to refer to when the person was admitted.

Detailed support plans were in place which covered 17 areas of people's care needs, including personal care, mobility, nutrition and hydration, social and emotional well-being, communication, personal histories and nursing needs. The support plans were personalised and provided details about what was important for people. There was reference to people's wishes and how they wanted their care needs to be met. For example, we saw records where people had requested specific times of the day for when it was best to meet their personal care needs. We spoke with people who confirmed this and told us that staff would do their best to work around people's individual needs. One person, who received personal care from the domiciliary care team on a daily basis, told us how they could arrange with staff when they wanted support so it would fit in with their plans. Each person was checked every morning by staff and some people had memos on their doors, with information about what time they would like to be woken up or for staff not to visit after a certain time. One person said, "Every morning at 6am they come efficiently and tell me when they will come back to help me with my shower."

Care plans were detailed and had been appropriately updated when there were changes, with regular reviews on a monthly basis. This meant that there was an up to date record for staff about how to meet people's individual needs. For example, one person had received support from an occupational therapist to provide advice and guidance for support with transfers. Detailed guidance was included for staff to support

the person in the safest way. Care was well evidenced, well documented and tracked regularly. We looked at a sample of daily logs that were recorded in people's care records. There was a daily personal care record which highlighted what kind of personal care had been offered and recorded. Daily logs recorded information about the day and overnight, with details about food and drink, personal hygiene, concerns and activities.

The provider focused on person centred care and was responsive to people's individual needs and preferences, enabling them to live as full a life as possible. The opportunities and facilities that were available for people to get involved in social activities and reduce social isolation were excellent.

Staff supported people to follow their interests, maintain relationships and take part in activities of their choosing. We spoke with an activity coordinator and a care team manager about the activities and getting people involved. Each person had their own activities folder with a daily activity log of what people had done, with monthly meetings during their review to discuss about what they would like to get involved in, focusing on their physical and sensory needs and levels of engagement. There was a comprehensive range of activities offered throughout the wards, including pottery, gardening, pet therapy, art and craft sessions, sing a long sessions with a pianist, quizzes and games, reminiscence sessions, tea dances with volunteers, and exercise activity sessions, which were available for everybody. The registered manager told us they had secured funding and showed us they had renovated one of the rooms into a sensory room, which could be used for one to one sessions. There was a well-designed activity room, a large balcony which allowed people to access outside without leaving the building and a gardening shed with raised beds for those who wanted to plant their own flowers. One person said, "We can do our own gardening if we wish, there are eight raised beds we can use and a lady buys plants for us. You don't have to pay for them."

There was also a bowls green and a putting green within the grounds, along with gardens with benches for people to use when the weather was fine. There was a gym on site with a resident physiotherapist to help people remain active and support them in overcoming any health problems or injuries. We spoke to one person about the bowls club, as they were unable to participate in a match due to ill health. They said, "The bowls team went to Cyprus and Portugal this year to attend events. They check you are fit to travel first though." We observed a game of bowls in progress on the second day of the inspection, as it was coming to the end of the season. A team of people who used the service were playing a group of senior staff. There was a very relaxed atmosphere, with people laughing and joking with one another, with a number of spectators. One person who was playing said, "I love it here. The staff are the best thing ever." People also had access to a cafe on site and a fully licenced bar, known as the 'Chelsea Pensioners Club', which was extremely spacious, comfortable and well decorated. One person said, "When my [family member] comes to visit, we always go and have a drink in there, it's great." There were also regular cocktail nights and themed nights throughout the year.

The registered manager told us about a number of other activities and formal events that were available throughout the year, where people had to apply due to limits on numbers. They added that if events were oversubscribed, they would look to split the event into two trips. One person told us that there was a waiting list for some oversubscribed events, one being the Buckingham Palace summer garden party. If you were not successful the first time, you were prioritised the next. There were day trips to the seaside, boat trips along the Thames, museums and national landmarks, such as Westminster Abbey. Comments from people included, "There are plenty of things to do, there's a programme of activities. We go to different places like Hyde Park, up the Shard, they couldn't do it better really" and "I used to go out on the trips, there were riverboat trips, Windsor, Houses of Parliament. If you put your name down generally speaking you can get on the trips." Due to the iconic status of the service and the people who used it, they had an annual event called Founders Day, where the royal family visit and all the people using the service and their families are

invited. They also had access to the Chelsea Flower Show, which is held within the grounds, along with other public events held there, such as musical concerts and the opera.

There was a real sense of a unique community spirit throughout the Royal Hospital Chelsea. They had their own post office, where one of the people from the Long Wards worked. Tours of the Royal Hospital Chelsea, including the museum, the Grand Hall and public gardens were available and were carried out by people using the service. The Christopher Wren chapel is open to the public as well as people using the service and their visitors for worship on a Sunday. Even though some people who had moved from the Long Wards to the Infirmary were less able to take part in this aspect of community life, it was still open to them. Some people in the Infirmary told us how they sometimes joined old friends at the historic parts of the hospital in the dining halls or Chelsea Pensioners Club.

We saw that people were encouraged to get involved and staff were aware of the importance of this, but also respected people's decisions if they were not interested. We saw in one person's care records it was highlighted they had depression and were at risk of low moods. We saw records that showed they were referred to the activities coordinator but also placed with one of the provider's many volunteers, to help the person and encourage them to get involved in activities of their choice. We observed a number of activities during the inspection, including a singing and dancing activity and a sitting exercise class, called 'Sit and be Fit'. Activities were well attended and staff and volunteers were well engaged with people. One person who was unable to communicate with us sat with a volunteer who was playing music to them through a headset. The volunteer explained to us that this was called 'playlist for life' which was a collection of people's favourite songs. Listening to these songs helped them engage with the music. They explained that before their mobility had deteriorated they had enjoyed dancing. Each person was supported to create their own playlist.

People were also supported to meet their religious needs. The provider had their own resident chaplain with two chapels on site. Wards had details of other chaplains representing other faiths. The chaplain told us that they had mass every week, but also had a shorter weekly service for those who were unable to stay for the full service. The chaplain told us it lasts about 15 minutes and they sing the same hymns, so people can get involved. We saw this on the first day of the inspection, with people being supported to the service by staff and volunteers. The chaplain added that they were able to meet people's wishes for those who wanted to have their funeral here.

People said they were happy with the service and would feel comfortable if they had to raise a concern. Comments included, "I can make a noise if I have to, I get treated royally. If you have problems you can normally correct it yourself", "I know how to make a complaint and I'm not afraid to say if there is anything wrong" and "I would raise it directly with the matron. She doesn't waste your time and will do something about it." One relative told us they were happy with how an issue was dealt with and that they responded very quickly. They added, "I'd feel confident if I had to raise any concerns to them."

One way in which the provider listened to people's experiences and concerns was through quarterly residents' meetings, dates of which were agreed on each ward. If people were unable to go, there were representatives from each ward who would feedback on their behalf. The Captain of Invalids also had weekly meetings with the registered manager to highlight if any concerns had been raised to them. People were asked for their general feelings about the care they received, the food, activities and any other business. We saw records from meeting minutes where people had commented on how good the activities had been. One person told us how the food had fallen below the usual standards and after raising it at a meeting, it had improved. They added, "They have upgraded the cutlery and crockery after we asked about it, so we are getting what we ask for."

There was an informal complaints book kept on each ward, with concerns recorded and action taken when followed up, and dealt with within each ward. A number of people we spoke with mentioned that there were problems with the laundry and that items could go missing or take a long time to be returned. The registered manager was already aware of this and had been proactive in working to improve it. At the time of the inspection, they had an external contract where laundry was collected and managed off site, then returned, which was when issues occurred. We could see that the provider had amended their recent annual survey to get feedback about a new personal labelled laundry service which could be arranged for a small fee. The registered manager told us that when informal complaints were received, they always responded to them to highlight they were taken seriously. We saw a sample of letters sent to people highlighting what actions had been taken.

Formal complaints were logged on a separate form and dealt with by the registered manager. There was an accessible complaints policy in place and explained to people when they moved in. Complaints were to be acknowledged in two working days and aimed to be resolved in 28 days. At the time of the inspection, there had been no formal complaints within the past 12 months. We saw samples of compliments received in the form of cards or comments in the annual friends and family survey. Comments included, 'Thank you for all the hard work and marvellous care you provide' and 'I'm overwhelmed by the patience, humour and care given by the staff to my [family member].'

Is the service well-led?

Our findings

People were very positive about the service and their day to day experiences of staff and management. People told us they felt comfortable talking with the registered manager and staff team, including the Captains of Invalids. Comments included, "It's 10 out of 10 here, there's no place I'd rather be", "It is very difficult to see what improvements could be made as we have so many things. Some are in the pipeline and some are already dealt with", "I think it's managed very well" and "I'm very satisfied with the way things are currently run here." Health and social care professionals we spoke with told us that the registered manager and staff team were very professional, approachable and that it was a pleasure to work with them.

The registered manager and senior staff team were extremely visible throughout the service and had a very clear understanding of their responsibilities in providing the best care and support possible for people using the service, with a strong emphasis on quality assurance and striving to improve the service. The excellent leadership observed throughout the inspection contributed towards a positive and caring team spirit, which added to the unique sense of community spirit throughout the service. Along with this, the leadership team were able to ensure high standards of care were achieved, which was one reason why they were awarded the beacon status for their dedicated work in end of life care and the work that had been carried out within their dementia ward.

Strong clinical leadership was observed during our discussions with unit managers. For example, the unit managers for the two units that provided nursing care demonstrated effective clinical knowledge, which they used for supporting staff with the planning and delivery of a high standard of nursing and personal care. They confidently presented clear knowledge of relevant theories of nursing care for older people. The culture of the leadership team filtered down to all levels of staff to ensure people received quality care.

The registered manager had a visible presence throughout the service and visited each ward every morning to see how people were doing. Throughout the inspection we observed a number of occasions where the registered manager introduced us to people or greeted people throughout the day. People responded warmly to the registered manager who had worked at the service for many years and knew each person well. People were very comfortable in her presence and enjoyed a laugh and joke and general conversation. Comments included, "I've been here for seven years and it is fantastic when they come around, things get done. It's a new life for me", "The matron comes round every morning. If there are any complaints I can put it to her then, she's pretty good" and "The matron comes every morning at breakfast. One day my poached egg was hard as a rock, she listens and does what she can. The next morning I got a good egg."

Staff told us they were well supported by the registered manager and senior staff team and had positive comments about the management of the service. They felt that the provider promoted a very open and honest culture and the staff handbook given to new starters included their mission statement, core values and the whistle-blowing policy. Their mission was to provide veterans with care and comradeship in recognition of their service to the nation. Staff discussed their five core values of decency, integrity, commitment, comradeship and standards throughout their employment to make sure they were putting them into practice. The registered provider had a clear vision and focussed on the people using the service,

making sure they had the opportunity to be as independent as they wanted to be. One care team manager said, "Everything we do, it is all about the core values."

Staff felt comfortable talking with management and if they had any problems they could speak with the management team, as they always made themselves available. One senior care assistant said, "I couldn't ask for anybody better. They are always approachable and make time for us." A care team manager said, "There is an open door policy and I have a great relationship with the manager. The support has been immense." A Captain of Invalids praised the service and the work of the registered manager. They said, "I can't think of a more caring, compassionate and thoughtful individual. I'm very proud to be a member of staff here. It is such an iconic institution and we are blessed to have some very dedicated staff."

The registered provider was aware of the challenges which faced the service and looked to find ways to overcome them. One of the challenges we discussed was the recruitment of permanent nursing staff, especially with the location being in one of London's most expensive areas. We saw that accommodation on site was made available for staff to help with the recruitment process. Another area discussed was maintaining and improving the standard of care within the home. The senior staff nurse responsible for training told us that everybody played a key role in achieving this and they had signed up to the Social Care Commitment. The Social Care Commitment is the adult social care sector's promise to provide people who need care and support with high quality services. It is made up of seven 'I will' statements, with associated tasks focussing on areas such as privacy and dignity. Each commitment focuses on the minimum standards required when working in care. The commitment aims to increase public confidence in the care sector and raise workforce quality in adult social care. We saw that 61 members of staff had signed up to this programme and it was discussed during the induction and staff supervision sessions. We saw records in people's files of completed development plans which highlighted how they carried out best practice. They added, "We have a responsibility to lift our image and uphold our standards."

They also highlighted how important it was to develop staff and encourage them to improve. There was an overall sense that it was a good place to work. A number of staff we spoke with had worked there for over five years and felt honoured to be helping the people they were caring for.

The registered manager and staff were extremely committed to understanding and helping people communicate their views, involving people as far as possible with the development of the service. We saw records from a ward meeting with people that discussed the type of information for short stay patients that should be produced, so that new admissions could be given an information card about what to expect and who to contact. We also saw that there was a separate survey for people on Campbell ward, for those living with dementia. They had used research from the Bradford Well-being profile to monitor how individual people with dementia were faring psychologically and socially. This is a tool developed by the University of Bradford, which specialises in dementia studies. The registered manager explained that they were carried out by a nurse who knew them best, including involvement from relatives and more time was given to allow them to be completed. They added, "This is the best way to help us understand them more."

The provider also sent out annual satisfaction surveys to people, friends and family, staff, people who used their domiciliary care services and people who had a short stay in the infirmary. We saw the results from the most recent surveys which had been completed this month. For the people who used the domiciliary care services, of the 46 respondents, there was a 100% satisfaction rate, with overwhelmingly positive comments received. One person said, 'All members of the care staff who I have met have one aim, dedication. I thank them all.' The information received from people living in the service was very positive, focussing on areas including daily life, staff, communication, food and drink and social activities. Areas that could be improved upon were highlighted and raised at meetings. 40 relatives responded and 95% were happy with the quality of care and attitude of staff. One comment said, 'We are very happy with the wonderful care [my family

member] receives and the wonderful dedication of all the staff'.

There was a strong emphasis on continually striving to improve the service for people. The registered manager had robust internal auditing and monitoring processes in place to assess and monitor the quality of service provided, which were carried out at daily, weekly, monthly, quarterly or yearly cycles. The registered manager had weekly compliance meetings with a senior nurse, the GP, physiotherapist and occupational therapist to discuss any healthcare concerns about people. These meetings also covered training records and complaints. Multi-disciplinary team meetings were held every fortnight and the registered manager had monthly meetings with the Captain of Invalids. There were quarterly Clinical Governance Oversight Committee (CGOC) meetings with the governor, commissioners, the registered manager, the GP and senior staff to give an overview of the service. One care team manager said, "When I started, I was invited to sit in on a number of meetings so I could get a feel for how the service works." We looked at the minutes for the past three meetings and saw that areas such as trends in hospital admissions, medicines errors, outcome of falls and deaths were discussed in detail. We saw that the number of serious injuries related to falls had reduced, with the majority of the outcome of falls resulting in minor to no injuries sustained, due to interventions that had been put in place following multi-disciplinary team meetings.

Specific audits of medicines on each ward were completed on a monthly basis and the pharmacist also visited yearly. We saw the quality assurance planner where each month highlighted what part of the service was to be checked, which covered areas such as supervisions, survey collections, care planning and dining and nutrition. There was also a development theme for each month which was discussed in staff meetings and supervisions. For example, in September it was dementia awareness and in October it was palliative care. There was also an annual health and safety audit carried out, with regular health and safety checks of the building, including the fire alarm system, mattresses, beds, call bells, water temperatures and the safe use of hoists.

All accidents and incidents were recorded and kept within each ward. We saw records covering three wards that showed all the circumstances and contributing factors had been documented, with a 24 hour follow up, with what action was taken and by whom. If a person had had a fall, a falls assessment was completed and the injury reviewed. We also saw they were followed up with multi-disciplinary team meetings being held and appropriate referrals to the GP and physiotherapist. Records showed that the registered manager analysed them so that any patterns or trends could be identified and addressed, in order to reduce the likelihood of incidences reoccurring and promote people's safety. Analysis from these records was discussed at the quarterly clinical governance oversight committee meetings. The registered manager said, "We always invite a member of staff to these meetings so they understand the importance of why we ask them to record this information and what we do with it."