Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Hospital of St John & St Elizabeth

60 Grove End Road, St John's Wood, London, NW8 9NH

Tel: 02078064000

Date of Inspection: 27 February 2014

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We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Hospital of St John and St Elizabeth
Registered Manager	Ms Christine Malcolmson
Overview of the service	The Hospital of St John and St Elizabeth is a private hospital that provides a wide range of healthcare services. These include medicine, surgery, orthopaedics, urology, paediatrics, urgent care and a charitable hospice. We visited the stroke unit and St John's Hospice.
Type of service	Acute services with overnight beds
Regulated activities	Diagnostic and screening procedures Management of supply of blood and blood derived products Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 27 February 2014, talked with people who use the service and talked with carers and / or family members. We talked with staff.

What people told us and what we found

The inspection focused on the hospice and stroke unit at the Hospital of St John and St Elizabeth. We spoke with numerous staff, including nurses a consultant and doctors. We also spoke with six patients in the hospice and one patient in the stroke unit. Patients were positive about the care and treatment they had received.

We found patients received safe, effective care that was planned in a way that ensured their safety and welfare. Peoples' needs were assessed and reviewed by a multi-disciplinary team, however, the outcomes from these meetings were not always recorded on the patient notes. Initial assessments were conducted in the hospice and recorded in patient notes. Assessments in the stroke unit were not always recorded.

Information was provided in a format that met people's needs to ensure they understood and were able to make decisions.

There were arrangements in place to deal with medical emergencies. There were systems in place to monitor the quality of service provided.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

Reasons for our judgement

The inspection focused on the hospice and stroke unit at the Hospital of St John and St Elizabeth.

People who use the service were given appropriate information and support regarding their care or treatment. We spoke with six patients in the hospice and one patient in the stroke unit. The patients we spoke with said they were well informed about their care, treatment and support choices at all stages of their contact with the hospital. They said they had clear explanations about their medical conditions and treatment options from their consultants and other staff involved in their care. One patient told us "The doctors are prepared to listen to what you have to say and then decisions are made together rather than them just telling you what will be done"

We saw from records that people were involved in making decisions about their care. Patients' files recorded their preferences and choices. Patients' pre-admission assessments covered their religious and cultural needs, including food, worship and preferred language in addition to their clinical needs.

We saw examples of the written information available to people in the wards visited. For example, we saw a pre admission booklet that was given to patients in advance of their stay at the hospital and this included details about housekeeping matters, the services available, nutrition and other matters. Detailed information was available in relation to the specific care being given and this could be translated into a different language within 24 hours if required. The provider had a website that included information about the hospital, the services provided and information for people coming into the hospital.

People's diversity, values and human rights were respected. We found people's privacy and dignity was respected as each person in the stroke unit had a private room and en-suite. The hospice consisted of two single sex bays. We observed staff knocking on patient's doors before entering and introducing themselves by their name and role. The curtains were drawn and patients' beds in the hospice. Staff told us there was access to

interpreters in a range of languages, if required.

Patients had regular opportunities to have their religious and cultural needs met. There was a Catholic chapel on site as the hospital was a religious foundation. The chaplain was responsible for facilitating links with other faith groups as appropriate to meet people's needs. In addition to advice from the chaplain there was a range of resources available for clinical staff to help them understand death and dying from different cultural perspectives.

Overall, we found staff were responsive to personal preferences and different cultural needs and expectations.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We spoke with six patients in the hospice and one patient in the stroke ward. The patients we spoke with told us they were very happy with the care and treatment they had received.

Care and treatment was planned and delivered in a way that was intended to ensure patient's safety and welfare. On the stroke unit patients were under the care of a specialist consultant. Nursing and health professionals involved in the patients care carried out a range of assessments and developed a plan of care. There was evidence of multi-disciplinary team meetings to ensure people's care was coordinated and all members of the team were involved and kept up to date with changes in treatment and care. There was a modified early warning system (MEWS) used to ensure that staff responded quickly if a person's condition began to deteriorate. Staff recorded vital sign observations such as temperature and blood pressure which were scored. If a person had a score of three or more staff were required to contact the Resident Medical Officer (RMO) who would come and assess whether the person needed more intensive care or required other treatments.

Patients were not admitted acutely after a stroke but could potentially be accepted once 72 hours had elapsed since the onset of their stroke and the diagnosis of stroke was confirmed. We saw that the unit had the necessary medical and investigative resources to deal with the medical complications of a stroke, to confirm the cause of a stroke (and of transient ischaemic attacks) and to identify a strategy and provide treatment to prevent further strokes. There were facilities for patients to be followed up by consultants and therapists after discharge from the ward if appropriate.

We looked at four case records in the stroke unit. These provided a detailed account of the medical history, treatment given and assessments made by therapists, and of the patient's progress in therapy. There were clear indications that the patient's cognitive and emotional state were being monitored and responded to during therapy. Some observations by nursing staff were also included. However, the provider may wish to note that only one report from a multi- disciplinary team (MDT) meeting was found in one of the four files reviewed and this consisted simply of a list of the patient's current impairments.

Hospital admission forms on the stroke unit were not always fully completed by the resident physician. Forms recording the results of initial clinical assessments were not fully completed and the initial neurological state of the patient was not fully recorded. However, we did see that these matters were fully considered and addressed by nursing staff and therapists in their assessments of the patients.

In the hospice we found that people's care files contained completed referral forms, which detailed why they were referred and their care and treatment needs. In the hospice patients were assessed by a multi-disciplinary team including occupational therapists, physiotherapists, dieticians and other professionals as needed. Risk assessments were carried out for pressure sores, falls and people's psychological needs were noted. We saw that risk assessments were managed appropriately. The hospice staff developed person centred care plans for those staying there. Assessments and care plans were reviewed and updated as needed.

All staff we spoke with understood the patients' nursing needs and how they needed to be supported. Staff told us the daily handovers were detailed and helpful to them in providing care.

In the hospice we found that people's clinical notes were updated to show any changes that were required in the care and treatment they received. We observed staff responding promptly to requests for assistance from patients and visitors. Call bells were answered promptly and we witnessed professional and compassionate interaction with patients and their relatives.

Patients at the hospice could also use the dedicated day centre which offered relaxation therapies such as massage, opportunities to socialise with outpatients and other staff. There were also exercise groups and a garden. We saw there was a gym that had dedicated slots for therapies for patients with stroke and an activity room that enabled detailed assessments to be undertaken by Occupational Therapists. However, the provider may wish to note that there was no dedicated area for recreation for stroke patients.

There were arrangements in place to deal with medical emergencies. All clinical staff received annual intermediate or advanced life support training, depending on their job role. The provider had ensured the resuscitation trollies were standardised across the hospital and we saw all items were in date and records were kept of the daily checks. However, the provider may wish to note that these checks had not been recorded in the hospice for two days prior to our visit.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

Staff had been trained on how to recognise abuse and staff we spoke with gave examples of potential abuse. The hospital had procedures in place to prevent abuse from happening and provided annual training to staff in safeguarding vulnerable adults and children.

There was a safeguarding policy and procedure in place. We discussed safeguarding with numerous members of staff. They all knew how to report a suspected safeguarding incident.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

New staff received a corporate induction which included statutory and mandatory training. New staff were supernumerary for two weeks and had a structured three month probation period. Staff completed a specific induction pack which included monthly expectations. Staff had to demonstrate they met their targets to successfully complete their 3 month probation. New staff had a mentor.

The policy of the hospice and the stroke unit was that staff were expected to take personal responsibility for ensuring their training was up to date and recording it. Training opportunities were advertised to staff by email. Individual's training status was checked at quarterly supervision and at appraisal meetings.

Records showed that all staff received annual appraisals, which staff confirmed.

Nursing staff and care assistants, including bank staff, told us they had undertaken mandatory training in moving and handling, fire safety and basic life support. One member of the team had undertaken training in advanced life support. Staff undertook training in information governance every year. Safeguarding training had been given by the deputy matron within the past year.

Additional training was available. Nursing staff were encouraged to study for a degree or masters and had eight days study leave. Hospice staff were encouraged to develop their understanding of palliative care and gain specialist qualifications and stroke unit staff were required to have previous experience in the care of stroke patients. The hospital ran study days on numerous subjects including the spiritual and religious aspects of dying. We saw a recent in-service training programme for training sessions for hospice staff covering topics such as wound care, motor neurone disease, psychology and cognitive behavioural therapy. A number of hospice staff had undertaken training in Advanced Communication which they had found helpful. We were told that staff attending training were encouraged to share their learning with others on the unit.

All grades of staff were provided with group supervision and an annual appraisal. Staff conducted quarterly review meetings with staff where they discussed goals and whether

they were meeting their objectives. Staff could also get individual support and supervision from the Chaplain or bereavement counsellor where required.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

The hospital used a variety of methods to assess the quality of the service overall. This included clinical audit, analysing incident reports from Datix and gathering feedback from patients.

People who use the service and their representatives were asked for their views about their care and treatment and they were acted on. Patients were asked for their views through a patient satisfaction survey. Patients were asked to complete a patient satisfaction questionnaire at the time of their discharge. Staff told us they used the feedback to gain a better understanding of people's views and make service changes as appropriate. We saw from the feedback returns that patient satisfaction was consistently high.

There was a programme of audit to monitor the quality of the service and environment. These included record keeping, consent and cardiac arrest calls. However, the provider may wish to note that there was no specific system of audit for the stroke unit.

There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. Incidents were electronically recorded and submitted to the relevant person or department for investigation and review. Important communications with staff regarding changes in procedures was disseminated through staff meetings and staff confirmed this with us.

There was a complaints procedure in place and patients told us they would feel comfortable reporting a complaint to staff if they had one. Complaints were collated and analysed for trends on an annual basis. We were given examples of changes made as a result.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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