St Joseph's Hospice Association

St Joseph's Hospice

Inspection report

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Date of inspection visit:
26 July 2016
27 July 2016

Date of publication:
05 September 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This announced inspection of St Joseph's Hospice took place on 26 & 27 July 2016.

St Joseph's Hospice provides care and support people with progressive, degenerative conditions and for people with brain injury and terminal illness. The hospice also provides end of life care and support to families of terminally ill patients. St Joseph's is run by St Joseph's Association which is a registered charity and company which also runs a number of hospices overseas.

The hospice has accommodation and facilities for 29 people across Liverpool, Sefton and West Lancashire. There are three units; St Francis House with eight ground floor rooms and 10 single rooms on the first floor; San Jose building has 11 ground floors single rooms.

The service is supported by a local consultant in palliative medicine, other consultants who specialise in psychiatry and elderly medicine and local GPs with an interest in palliative care. The hospice is partially funded by the NHS and through fund raising.

People were admitted to the hospice from their own home, hospital, or by a local clinical commission group (CCG). CCGs are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.

There was a registered manager in post. 'A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run'.

St Joseph's has a board of Trustees, a number of committees, including a clinical governance committee, a chief executive officer (CEO), clinical director (registered manager) and director of income generation.

During our inspection we found a number of breaches in our regulations.

We looked to see if there were systems in place to ensure the proper and safe handling of medicines. We found medicines were poorly managed and current practices put people at risk.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. We found on inspection however that the safeguarding process had not always been followed to protect people from abuse. Incidents that affected people's welfare had also not always been reported to us in accordance with our regulations. This showed a lack of monitoring around risk.

People's care planning lacked sufficient detail to help ensure their care needs were being met. Care

monitoring records such as diet, fluid and positioning charts were not always completed which meant that an accurate evaluation of care needs could not be made.

The service did not operate an effective system for handling, recording and responding to complaints.

Although systems were in place there appeared to be a fragmented approach in respect of identifying and controlling risks and concerns, reporting on lessons learnt and actions taken. This meant the governance was not robust to assure a safe effective service.

People were supported by sufficient numbers of staff to provide care and support in accordance with individual need. We saw that people received care from a multi-disciplinary staff team which included nurses who were trained in end of life care, care staff, volunteers for complimentary therapies, pastoral staff and a family support officer. People told us the staffing numbers were good and that they received support when they requested and needed it.

Staff sought advice and support from health professionals to optimise people's health and provide continuity of care. Medical cover was provided at the hospice Monday to Friday and staff had access to the routine 'out of hours' GP service and telemedicine via a local clinical commissioning group (CCG).

Risk assessments were in place to ensure people's health and safety. The risk assessments helped to help mitigate those risks and to protect them from unnecessary harm.

The provision of family support was seen as important and people who used the service and relatives had access to a family support officer. Their role also included pre and post bereavement support.

A high standard of cleanliness was maintained at the hospice. Systems and processes were in place to monitor standards of hygiene and control of infection.

The hospice provided suitable accommodation and equipment to meet people's individual needs.

Recruitment procedures were robust to ensure staff were suitable to work with vulnerable people.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed and contracts in place for services and equipment. This included fire prevention.

Staff told us they were supported through induction, on-going training, supervision and appraisal. The formal training programme for staff included end of life qualifications as part of their professional development. Staff told us the training programme was good.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to hospices. Staff were trained in the principles of the MCA and the DoLS and were knowledgeable in the main principles of the MCA that they applied in practice. They assessed people's mental capacity when necessary and when applicable they held meetings to make decisions on their behalf and in their best interest. This meant that people's rights were protected and respected. People's consent was documented in the care files we saw to evidence their inclusion around their care and treatment.

People's dietary needs were assessed and people told us they enjoyed the food. We saw people were offered a variety of nutritious meals.

Our observations showed staff placed a high value on building close relationships with the people they supported. Staff showed a caring nature when supporting people; staff took time to listen and to respond in a way that the person they engaged with understood.

People told us their privacy was respected and staff approach was genuine and warm. They told us they were pleased with the care and treatment they received. A person said, "The care is brilliant."

People were involved in the planning and review of their care. People told us their views were listened to and their wishes were recorded in care. We saw staff sought consent when supporting people with their care.

There was a clear management structure and staff said they were supported by the management team.

You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

The service were not always following safeguarding procedures to protect people from abuse.

We found systems in place to manage medicines were unsafe. Current medicine practices put people at risk.

Risks to people's safety were assessed and control measures in place to help ensure their safety. Environmental hazards were identified and measures taken to ensure people lived in a safe comfortable environment.

Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

There were enough staff on duty at all times to help ensure people's care needs were consistently met.

Is the service effective?

Good

The service was effective.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity being made.

We saw people's dietary needs were managed with reference to individual preferences and choice.

Staff said they were supported through induction, appraisal and the hospice's training programme.

Is the service caring?

Good

The service was caring.

When interacting with people staff showed a caring nature with appropriate interventions to support people.

People told us the staff were respectful and polite at all times. We saw people being cared for in a respectful manner during the inspection.

Staff demonstrated a good knowledge of people's individual care, their needs, choices and preferences. People's end of life choices were discussed with them sensitively and at the appropriate time. These wishes were recorded and acted on by the staff.

Families and carers received support from the staff during their family member's stay at the hospice and during their period of grief.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care planning lacked sufficient detail to help ensure their care needs were being met. Care monitoring records such as diet, fluid and positioning charts were not always completed which meant that an accurate evaluation of care needs could not be made.

The service did not operate an effective system for handling, recording and responding to complaints.

People told us they were given plenty of opportunities to express their views about their care, treatment and other areas of the service. Staff took this information into account when planning and delivering care.

Nursing cover was provided 24 hours a day on the units with two regular local general practioners (GPs) overseeing people's care and treatment. This medical cover enabled people to be seen every day should there be concerns about their health and for new people admitted to the hospice to be seen promptly.

Is the service well-led?

Requires Improvement

The service was not always well led.

Although systems were in place there appeared to be a fragmented approach in respect of identifying and controlling risks and concerns, reporting on lessons learnt and actions taken. This meant the governance was not robust to assure a safe effective service.

The home had a registered manager in post and there was a

clear management structure in place. We received positive comments regarding the management of the service from people who were living there, relatives and staff.

Staff were aware of the home's whistle blowing policy and said they would not hesitate to use it. They told us they could speak up if they had a concern.

St Joseph's Hospice

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 26 & 27 July 2016 and was announced.

The inspection team consisted of an adult social care inspector, a pharmacist inspector and a specialist advisor (SPA) with experience in hospice services.

Before our inspection we reviewed the information we held about the service. We looked at notifications and other information we had received about the service. We contacted the commissioners of the service to obtain their views.

During the inspection we spent time with six people who were living at the hospice. We spoke with the registered manager, 11 staff, including three unit managers, registered nurses, care staff, cook, and Chief Executive Officer (CEO). We also spoke with five relatives during the visit.

We viewed a range of records including, care documents for six people who were living at the hospice, four staff personnel files, medicine records, records relating the running of the service and a number of the provider's policies and procedures.

Inadequate

Is the service safe?

Our findings

At this inspection, we checked the medicines and records for six people (two from each unit). We spoke with five members of staff including the registered manager, a registered nurse and three nurses who were working as non-medical prescribers. A non-medical prescriber is a person who can prescribe medicines, but is not a qualified doctor. We found medicines were not being managed safely.

There was no clinical pharmacy service to provide advice on prescribing or medicines optimisation. A hospital supplied the home with Controlled Drugs (CDs), (medicines that require extra checks and special storage arrangements because of their potential for misuse) and a member of staff from the hospital completed CD audits every three months.

When talking with the nurses they told us they had not received any recent medicine training or had their competencies checked to ensure they administered medicines safely.

Medicines were obtained from a local pharmacy, which provided a service Monday to Friday and on Saturday mornings. Two members of staff told us that people did not always have a supply of medicines because of the limited pharmacy service. St Joseph's Hospice had introduced a system where medicines for one person were shared with other people to prevent the delay in medicines being given. We informed the registered manager that this was inappropriate practice.

Medicines were not stored securely on the first unit. The medicine room, including the cupboards and fridge, were unlocked when we arrived onto the unit, and no staff were present. The medicines trolley was locked to the wall to prevent it from being taken; however, the lock to the medicine trolley was broken. Staff told us this had been broken for several weeks. This meant there was a risk medicines may have been accessible to unauthorised persons.

We checked the storage arrangements for medicines requiring refrigeration. Fridge temperatures on the second unit had been recorded as less than two degrees Celsius for two weeks, and 13.3 degrees Celsius for seven days. The recommended range for storing medicines is between two and eight degrees Celsius; staff could not tell us what action had been taken to address this. This meant we could not be sure medicines stored in the fridge were safe to use.

Medicines audits were completed on each of the units by a registered nurse. The audits highlighted that stock balances were not correct and it was unclear whether medicines had been signed for, but not given. Incorrect stock balances were found on all three units and was continuous throughout the audits. The service could not show us what actions they had taken to reduce this. We found one person who was taking a medicine to relieve constipation had more sachets than expected and a second person had too many tablets left for three of their medicines, which included a medicine for cancer treatment. The first person also had also been prescribed a seven day course of antibiotics, but the Medicines Administration Record (MAR) had been signed on eight days.

Medicines were not always given as prescribed by the doctor. Two people on unit one were prescribed a fluid and food thickener to aid swallowing. A member of staff explained the quantities of thickener used to make a drink, which was different to what was advised by the manufacturer. Staff did not record when thickeners were used, and one of the people had two different consistencies documented in their care plan, which meant it was unclear what consistency should be used ; using the wrong consistency could increase the risk of choking.

This is a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had systems to protect people from abuse. However, they were not always used effectively to protect people from the risk of unsafe care. A safeguarding policy was in place along with local area safeguarding procedures for staff to follow. The staff training plan evidenced training in safeguarding adults and people were cared for by staff who knew how to recognise the signs of possible abuse. Staff told us they would report any concerns they deemed as safeguarding to their unit manager or the registered manager and contact details for reporting to the local authority were available for staff referral.

When talking with the registered manager about safeguarding people from abuse we found several areas of concern which should have been safeguarded. We also found that we had not always been notified of incidents that had occurred at the service. The registered manager said they would notify us retrospectively and would seek to review the regulations and guidance available regarding notifications. This shows a failure in the way the service monitors when reporting on any areas of risk.

This was a breach of Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us they felt safe when receiving treatment and care. Their comments included, "Yes I feel safe" and "Staff are vigilant." When talking about their medicines, people said, "I get my pain relief when I need it" and "If I need additional pain relief, I get it."

We saw how accidents and incidents were recorded and discussed at team meetings. We asked the manager to tell us how accidents and incidents were analysed to identify trends or patterns. The registered manager told us there was no formal audit of accidents and incidents though incidents were discussed at clinical governance meetings and team meetings.

Risks associated with people's plan of care had been assessed with people's consent. The risk assessments helped to help mitigate risks and to protect people from unnecessary harm. The care files we looked at showed staff had completed risk assessments in areas such as, moving and handling, falls, skin integrity and nutrition.

We looked at the staffing arrangements for the service. People told us there were enough staff to meet their needs. Their comments included, "Good number of staff around" and "Help is on hand when you call, there are always staff here to help." People told us they felt safe when staff were looking after them.

During our inspection we saw there were sufficient numbers of staff on duty to keep people safe and meet their needs. This was confirmed when talking with staff and looking at the staffing rotas for the past four weeks. We saw that when people needed care and support this was provided in a timely manner; no one was left waiting which would increase their anxiety.

On the first day of our inspection 26 people were receiving in-patient care on the three units. Each unit had a unit manager (registered nurse) and they along with the registered manager were on duty during the inspection. They told us two registered nurses were always on duty during the day for each unit; this included the unit manager if rostered to work. There were three care staff on each unit and ancillary staff including administrative, maintenance, kitchen and domestic staff. At night the patients were supported on each unit by a registered nurse and a member of the care team.

The hospice had a family support officer, two volunteers who provided complimentary therapies two days a week, for example, aromatherapy, a site manager and a chaplaincy team for spiritual and religious support. A family support officer offered pre and post bereavement counselling for people, their relatives and staff.

Staff told us there was an 'on call' system for 'out of hours' cover. Staff told us the unit managers along with the registered manager were always available to provide support in an emergency.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We looked at four staff files and asked the registered manager for copies of appropriate applications, references and necessary checks that had been carried out. We saw these checks had been made so that staff employed were 'fit' to work with vulnerable people. Evidence was available to show where staff were registered with appropriate professional bodies such as the Nursing and Midwifery Council (NMC). The NMC regulate nursing staff and ensure professional standards; once they are registered they receive a pin number. These were checked by the registered manager to ensure they were current. The records that we saw confirmed this.

Risk assessments were in place for the general running of the home and checks were made by the home's maintenance person on fire safety and water systems for example. Arrangements were in place with external contractors for regularly checking and monitoring the safety of equipment and services which included gas, electric, moving and handling equipment, legionella compliance and fire prevention. The records that we saw indicated that checks and servicing had been completed in accordance with the required schedules.

Staff told us they received fire training and that fire drills took place. Minutes from a team meeting showed fire safety as an agenda item to support staff's understanding around fire safety and expectations in the event of a fire.

When we looked round the hospice we found it to be clean. Staff had access to personal protective equipment (PPE), such as aprons and gloves and we saw they used this when providing care. This meant that appropriate action was taken to ensure the home was clean and the risk of infections or contamination limited. A registered nurse was appointed the role of infection control lead to monitor standards of cleanliness and oversee infection control training for new and existing staff. Standards of cleanliness were audited to help assure good standards of the control of infection; a recent infection control audit scored 96%.

Good

Is the service effective?

Our findings

People on the units were complimentary regarding the treatment and care they received. Their comments included, "I couldn't be in a better place", "I am well looked after", "They look after you very well, "Very good care" and "If I don't feel comfortable the staff will come and sort me out." A relative said, "I would like to tell you how brilliant St Joseph's is. This is the best place."

People told us they were given plenty of opportunities to express their views about their care, treatment and other areas of the service. They told us that they thought there was enough staff to support them when the needed assistance and this support was given in the way they wanted. Staff told us how they took this into account when planning and delivering care. People's comments included, "Very good care" and "First class care, so impressed."

When talking about the standard of meals people said, "Lovely meals", "I'm sorry I didn't come here in the first place the food is really good", "I find the food good If I don't want what they have prepared for lunch they will prepare what I ask for " and "Meals are very nice, can't complain."

Relatives also expressed their satisfaction for the service, "They take care of my family", "I have been very impressed with the care that has been given to (family member)" and "It's not just about procedures, they treat (family member) as a person… as an individual." Relatives and people we spoke with felt the staff were skilled at supporting them.

The hospice offered an in-patient service for people with progressive, degenerative conditions and for people with brain injury and terminal illness. The hospice also provides end of life care and support to families of terminally ill patients. We saw that people received care from a multi-disciplinary staff which included nurses who were trained in end of life care, care staff, volunteers for complimentary therapies, chaplaincy staff and a family support officer.

Nursing cover was provided 24 hours a day on the units with two regular local general practioners (GPs) overseeing people's care and treatment. This medical cover enabled people to be seen every day should there be concerns about their health and for new people admitted to the hospice to be seen promptly. This cover was provided Monday to Friday and staff had access to the routine 'out of hours' GP service and telemedicine (electronic access to clinical assessment) via a local clinical commissioning group (CCG). A local consultant in palliative medicine and other consultants who specialise in psychiatry and elderly medicine provided further support. When talking with staff we found them to be knowledgeable regarding people's plan of care and medical treatment.

We looked at how people were supported with their nutrition and hydration. People's nutritional needs were assessed and they had a plan of care to support their nutritional needs, requirements and preferences. Staff completed referrals for dietetic support at the appropriate time. We saw that a nutritional screening tool was used to identify people's nutritional requirements and referrals made for external dietetic support should a risk be identified. The staff did not use MUST – this is a 'five-step screening tool to identify adults,

who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan'. Staff completed their own nutritional assessment but told us they were looking to implement the MUST as they appreciated this formal audit tool would be more beneficial when assessing people's nutritional state. People had a plan of care which outlined the dietary support they needed and wished to receive.

We spoke with the cook who told us about the meals they prepared and people's dietary requirements, allergies and preferences. They also told us they met with people to check meals were to their liking. This was confirmed when talking with people at the hospice.

People were supported with their lunch appropriately and with dignity and respect. The majority of meals were served on individual trays to people in their rooms. We saw people were offered a choice of two hot meals at lunch time with a lighter meal of cold or hot foods at tea time. The cook told us that people could have whatever they liked and often separate meals were prepared if the menu choice was not to people's liking.

A four week menu was available and people were offered a choice of two hot meals at lunch time. There was however no record of meals prepared at tea time. We were told that staff informed people of the tea time choice and an alternative if this was requested. The cook told us the catering staff had all the information they needed to prepare meals in accordance with individual need and preference. Nutritional sheets recorded people's dietary requirements and needs, for example, whether a person required a pureed diet or ate a special diet. We saw that attention was paid to ensuring the correct consistency for pureed foods and retaining the colour and shape to make the meal more appetising.

People were offered a good choice of fresh fruit and vegetables and hot and cold drinks and snacks were available throughout the day. There were small kitchen areas where people and their families could make themselves drinks and the cook told us the kitchen was left open should staff wish to prepare light snacks or drinks for people.

We looked at staff training and support. Staff had undertaken training and their competencies checked to ensure they had the skills and competencies to meet people's needs. Training was delivered in a variety of ways including e-learning, DVDs and face to face. The registered manager showed us the staff training plan and this evidenced training in areas such as, moving and handling, first aid, food safety, infection control, health and safety, nutrition, ethics, dementia care, fire safety, mental capacity, safeguarding, bereavement and advance care planning. More bespoke training was provided to support people with their clinical needs, for, example, catheter care, wound care, eye care, enteral feeding, tracheostomy care, blood glucose monitoring, respiratory disease and brain injuries.

For a person who required very complex care and support, staff told us about the training they had undertaken and the on-going clinical support they received from external agencies. Staff told us their training and supervision sessions enabled them to carry out their roles effectively and develop their knowledge and skills. We saw dates of supervision and appraisal meetings.

Nurses were supported with their nursing revalidation with the Nursing Midwifery Council (NMC) along with obtaining professional qualifications in end of life care up to degree level. 88% of staff had achieved a formal qualification in care, such as an NVQ (National Vocational Qualification) Diploma or equivalent. This demonstrates a commitment to learning and development.

New staff received a full induction working alongside a more experienced member of the staff team. We saw

the introduction of the Care Certificate for health care workers. This is 'an identified set of standards that health and social care workers adhere to in their daily working life'. The Care Certificate requires staff to complete a programme of training, be observed by a senior colleague and be assessed as competent within twelve weeks of starting. A member of the care team told us about their care induction and how they were working through the standards. They told us they felt fully supported and were able to ask questions at any time. The staff member said, "It's been brilliant so far."

At this inspection we looked to see if the service was working within the legal framework 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The registered manager told us how consent to receive care and treatment at the hospice was established before admission. They told us that if a person was not able to consent to their admission or subsequent care and treatment then a best interest meeting would be held. We saw examples of this in respect of advance care planning for end of life care.

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 MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw documentation related to DoLS was contained within people's care records and that the manager kept an oversight document to track applications and expiry dates.

Where people had capacity to make their own decision about the care they received then this was documented. Where people did not have capacity to make their own decisions then staff had followed the MCA. There was evidence of appropriate processes being followed where people had DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) notifications in place following best interest meetings. Staff understood about supporting people to make personal choices where ever possible. This meant appropriate action had been taken by the home to ensure proper and legal processes were followed in relation the MCA and DoLS.

During our inspection we observed staff seeking people's consent before supporting and proceeding with an intervention or support in respect of personal care. We did however witness and incident where it appeared the person's consent was not obtained in respect of taking a media image. We raised this with the registered manager and have asked for an incident report to be forwarded to us, along with clarification of the hospice's policy and procedure regarding obtaining verbal and or written consent when a person has or does not have capacity to make a decision. Following the inspection the service provided a detailed incident report which clarified verbal consent had been sought in this instance. They also informed us the consent policy was being revised to provide assurance around gaining consent for recording any media images and to follow up with written consent as soon as possible. The service took prompt action to respond to us and to ensure the consent policy was fit for purpose.

The hospice was well presented; the units were well lit, spacious, comfortable and airy. People had access to a call bell for assistance, pressure relieving equipment, specialist beds and a therapy bath. When reviewing

equipment we found a lack of safety checks for specialist mattresses to ensure they were working effectively. Following the inspection the registered manager said a chart was now in place to record these safety checks.

There was plenty of communal space on each unit and people could sit out or enjoy walks in the hospice's well maintained landscaped patios and gardens. We saw people enjoying the hospice's grounds during our visit. A relative told us how lovely the landscape was.

Good

Is the service caring?

Our findings

Our discussions with staff, people at the hospice, their relatives and our observations showed staff placed a high value on building close relationships with the people they supported. This helped people to feel respected, understood and cared for with genuine warmth. The hospice's patient guide states, 'The emphasis at St Joseph's is to try and provide a caring environment with as homely atmosphere as is possible'.

We found there was a great deal of emphasis on understanding and meeting people's emotional needs and this support was provided in a calm, friendly and relaxed environment. People said they were treated with respect and good there was good adherence to this when receiving personal care. People's comments included, "The staff are lovely. They are so nice", "The staff are lovely and very helpful" and "The staff are so good to me, nothing is too much trouble for anyone." Relatives said, "The staff do all they can…nothing is too much trouble", "They (staff) have had (family member) laughing", "They (staff) have a great relationship with (family member)", "The staff are brilliant with (family member)", "Staff are absolutely lovely", "The staff have taken a lot of pressure off the family" and "We have never seen (family member) distressed."

People said they were consulted about their care and treatment and their views were listened to, respected and acted upon. This was reflected in the care documents we looked at. People at the appropriate time had an advance care plan (ACP) in place to support their needs and wishes regarding end of life care.

The staff we spoke with were passionate about their role and told us how they gave individual care to people and their families. They told us the staffing numbers were good and this enabled them to spend a lot of time with people. A staff member told us they felt it was, "An honour and privilege to do this work." Staff said they were not rushed in their care delivery as good staffing numbers enabled them to spend time with people on a 'one to one' basis. This was confirmed by the people we spoke with. A person said, "They (staff) have so much time for you, they come and sit and hold your hand if you are frightened or anxious. They don't leave you until you feel better."

Support was given in a patient, respectful and caring manner. Staff demonstrated a genuine interest and concern regarding people's welfare and spent time with people to provide companionship when they were alone. Staff used gentle touch where appropriate such as holding someone's hand or gently touching their arm to offer reassurance.

People's rights to privacy and dignity were respected. We saw staff knocking before entering people's rooms and also waiting to be advised they could enter. Staff were aware of people's preferred term of address and also checked with people to see if they were 'up to' receiving visitors before allowing visitor to enter. A person told us this was important to them.

There were no restrictions on visiting. There was no provision of a relatives' room for an overnight stay though people could stay at their family member's bedside if they so wished.

The service took account of people's religious and spiritual needs also. Holy Mass was held on Sundays and Holy Communion and private prayer offered to people. The hospice had links with local clergy from other denominations and chaplaincy support was also available in the evenings and weekends. People and their families had access to a chapel for prayer and quiet reflection.

A pre and post bereavement service via the family support officer was offered to people and their relatives with a card sent to relatives six week after the death of their family member. Relatives were asked if they would like to meet with the family support officer as a means of support following the death of a family member. Bereavement leaflets were also available for relatives and carers.

A person at the hospice told us how much they enjoyed the hand massage and appreciated the complimentary therapy sessions offered to them.

Advocacy information was available should a person at the hospice wish to access this information.

Requires Improvement

Is the service responsive?

Our findings

People had a plan of care to identify the care needs. A nursing care plan provides direction on the type of care an individual may need following their needs assessment. Care planning is important to ensure people get the professional care they need when they are at the hospice. Care plans cover areas such as, mobility, personal hygiene, pain management, skin integrity, constipation, assistance with personal care, psychological support, skin care, spiritual care and care plans for medical conditions that require clinical intervention. For example, an indwelling catheter, wound care/pressure ulcer care, tracheostomy care or tube for enteral feeding. Enteral feeding refers to the delivery of a nutritionally balanced feed via a percutaneous endoscopic gastrostomy tube (PEG). The PEG is passed into a patient's stomach to provide a means of feeding when their oral intake is not adequate. A tracheostomy is 'is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help a person breathe'.

We found a number of anomalies in respect of the five care files we reviewed. People's care planning lacked sufficient detail at times to help ensure their care needs were being met.

For example, a person's plan of care lacked detail around their tracheostomy care and staff were recording safety pressure checks of the tracheostomy twice a day instead of three times a day as stated in the plan of care. We saw the layout of the chart lacked a column for recording three times a day. This was rectified during the inspection to evidence the checks staff told us they were undertaking. We found other examples where there was a lack of detail recorded for catheter care and PEG care. For one person there was no record of the date of insertion for their indwelling catheter.

Care monitoring records such as diet, fluid and positioning charts were not always completed which meant that an accurate evaluation of care needs could not be made. For example a person who was receiving an enteral feed and who had a catheter, there was no intake and output chart in place to monitor this aspect of their care. Their intake and output were not therefore being recorded. We discussed this with the staff who told us about the care the person was receiving and we saw the person had received their enteral feed. For a person who had a plan of care for pressure relief there was no chart to record when the pressure area care for a change of position was given to monitor the condition of their skin.

This is a breach of regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection staff told us they were in the process of designing monitoring charts as they recognised this was an area that needed improvement. Following the inspection the registered manager advised us of the measures they were taking to improve the care records. This included the use of care charts to support people's plan of care. For example, a pressure area chart, food and fluid chart and tracheostomy tube pressure chart. They also informed us that a full medical and care review would take place by 8 August 2016 for people receiving care and support at the hospice. This action was confirmed with us.

People at the hospice had access to a complaints procedure and details of how to raise a complaint were available in the hospice's pack given to people and their families on admission. There were no individual complaint logs, complaints/concerns, actions and response to complaints were written in a hard back complaint book. This raises concerns around the security, storage and sharing of personal information held collectively under data protection.

We discussed with the registered manager a complaint received in January 2016. The hand written response did not address the care concerns raised by a family member. There was also no evidence of a formal written response to the complainant in accordance with the service's complaint procedure. In respect of complaint in March 2016 there was a hand written entry regarding the actions taken though again there was no formal response to the family member. We found the provider did not operate an effective system for handling, recording and responding to complaints.

This was a breach of Regulation 16(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the registered manager informed us they were reviewing the service's complaints procedure and instigating a separate complaints book and concerns book by 15 August 2016.

People and their relatives spoke positively of the care provided and told us they received care and support which was responsive to their needs. A person said, "I ring for help and the staff come as soon as they can and I see the doctor most days" and "Staff are on the ball, very caring." Relatives told us they were informed of any change regarding their family member's care and that staff provided good support. Their comments included, "Staff have kept me up to speed with what has been going on", "They also care for the family" and "I felt able to look at the care plans."

People received care and treatment from a multi health professional team. This included nursing staff and a local GP service which provided cover and visits to people at the hospice five a days a week. Care files recorded referrals to health professionals such as, dietician and speech and language therapy (SALT) team. People had a medical review every three months to monitor their health and medication. A chiropody service was available.

People were involved in decisions about their care and treatment; staff told us they would not proceed without people's full understanding and consent. We saw evidence of people's consent in their care files.

Information had been recorded around people's wishes for end of life care. End of life care relates to the care provided for a patient anywhere within the last year of life, up to and including death. The hospice had achieved accreditation with the Gold Standards Framework (GSF).The GSF provides evidence based training and support for staff who provide end of life care. Discussions with staff demonstrated their understanding of end of life care and people's wishes and care needs for end of life care were recorded. A person told us, "The care is first class for me, I could not ask for more support."

Requires Improvement

Is the service well-led?

Our findings

At this inspection we looked at quality assurance systems, including audits (checks) to check on risks, monitor performance and to drive continuous improvement.

Although systems were in place there appeared to be a fragmented approach in respect of identifying and controlling risks and concerns, reporting on lessons learnt and actions taken. This meant the governance was not as robust as it could be to assure a safe effective service.

The hospice had a clinical governance committee whose role is to oversee the quality of care offered to people St Joseph's. This is carried out by a process of assuring the compliance of systems and processes for the delivery of a safe and effective service. We saw minutes of clinical governance meetings held in April 2016 and July 2016. Agenda items included medicine management and, significant event and complaint analysis. In April 2016 due to the number of minor medicine errors the need for medicine training had been identified. This was raised again at the meeting in July 2016 and at the time of the inspection had not been actioned. We saw from minutes of team meetings that concerns around medicine management had been discussed though it did not appear that sufficient actions had been taken to reduce the risks identified.

In respect of medicines one of the non-medical prescribers told us that lessons learnt from medicine incidents would be emailed to staff and would be discussed at team meetings. There was however no formal process to ensure staff had read the email about medicine incidents and team meetings were held every three months, which may prevent the shared learning of medicine incidents. A team meeting from the week before we inspected did not state that medicine incidents had been discussed despite the on-going medicine incidents found on the weekly audits. Following the inspection a further medicine incident was identified which is a concern and evidence of the current auditing systems for medicines and sharing lessons learnt not being robust.

We looked at a number of significant event analysis reports. The details of the reports were mainly reflective and not all had been completed including lessons learnt and actions taken. There was no risk register in place to record domains such as, identified risks which would impact on the safety of people using the service, governance, complaints, staffing and organisational development. It was therefore difficult to fully assess the governance arrangements and how risks were being managed and actions prioritised in accordance with the level of risk identified.

This was a breach of Regulation 17(1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the registered manager was prompt to respond and provide a detailed action plan to address the areas of concern we identified during our inspection. We have since met with the senior management team and received assurance that appropriate and well timed actions are being taken. It has been agreed that a weekly update on actions taken will be sent to us. In respect of concerns raised with us by a local external agency and also with the service itself, the senior management team are now closely with

a local CCG in respect of improving governance and medicine practices.

The medicine action plan included medicine training and competency checks for the staff, introduction of a new cream chart, obtaining medication out of hours, checking drug fridge temperatures and medicines safely locked. A medicine management meeting had also been planned to discuss changes needed to improve medicine practices along with a review of actions taken at the weekly quality assurance meetings.

Feedback about the registered manager was positive and staff told us the registered manager was approachable. When discussing the management of the home with the staff we were advised that they would like the registered manager to take part in the hand over at shift changes and also do a walk around in the morning to meet 'patients' on the units. We passed this to the registered manager for them to consider.

Staff told us they understood the concept of whistleblowing and would feel supported if they needed to raise a concern. Staff advised us they attended meetings where information was shared about the service. They spoke positively regarding the leadership on the units.

Feedback from people using the service and families was very positive. Relatives made the following comments, "The stress has been eased by the quality of care" and "No faults whatsoever." We saw people and their families had access to a website to share their views and provide feedback about the hospice. Comments seen were very positive. The registered manager told us satisfaction surveys were not used for obtaining feedback.

The hospice had links with other hospices, hospitals and organisations for end of life care. Staff attended external training events and submitted data to Hospice UK for falls, pressure ulcers and medication errors to benchmark their practice.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured care was planned effectively. People's care planning lacked sufficient detail at times to help ensure their care needs were being met. This is a breach of Regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provided did not always safeguard people from abuse. This is a breach of Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person did not have a robust system in place to operate an effective system for handling, recording and responding to complaints. This is a breach of Regulation 16(1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not have a robust system in place to regularly assess and monitor the quality of the service. This is a breach of

Regulation 17(1) (2) (a) (b)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found medicines were poorly managed and current practices put people at risk. This is a breach of Regulation 12 (2) (g)

The enforcement action we took:

We served a warning notice