Sue Ryder

Sue Ryder - Nettlebed Hospice

Inspection report

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Ratings

Overall rating for this service	Good ●
Is the service safe?	**Requires Improvement** ●
Is the service effective?	**Requires Improvement** ●
Is the service caring?	**Outstanding** ☆
Is the service responsive?	**Good** ●
Is the service well-led?	**Good** ●

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

This was an unannounced inspection. There was a registered manager in post at the hospice. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law as does the provider.

Summary of findings

Sue Ryder - Nettlebed provides accommodation with specialist nursing care for up to 12 people with life limiting conditions. Sue Ryder - Nettlebed also supports people with life limiting conditions in their own homes and provides day therapy services to people in the community. Ten people were staying at the hospice on the day of our visit and 40 people were receiving support from the hospice in the community.

The service had systems in place to ensure people's medicines were safe; however these were not always effective. There was a risk that people may receive out of date medicines. People's care records were detailed but were not always clear and concise for staff to follow.

Staff working in the hospice understood the needs of the people and we saw care was provided with kindness and compassion. People had their needs met and their treatment was geared towards symptom and pain control. People, their families and friends told us they were happy with their care.

The hospice was a safe and clean environment for people at the end of their life. People told us they were safe in the hospice and had no concerns. When people or their families raised concerns the registered manager acted to ensure a positive goal was achieved and people's care needs were met.

People told us the support they received from all staff whilst receiving care in the hospice or in the community was great. People felt communication between hospice staff, other health care professionals and care agencies was effective and enabled their needs to be met.

Staff were appropriately trained and skilled and provided. They understood their roles and responsibilities, as well as the values and philosophy of the hospice. All staff including doctors, nurses, care staff and domestics received the training they needed to provide effective care and keep people safe. We saw all staff appeared knowledgeable and provided people with effective support. People were wholly positive about the support they received from staff.

People felt included and listened to by hospice staff. They told us they were always at the centre of their care and that staff were responsive to their needs. People told us their decisions were respected. People were kept comfortable and were never left in pain.

The registered manager and the provider assessed and monitored the quality of care in a way that promoted safety and quality. The hospice encouraged feedback from people and families, which they used to make improvements to the service. The senior management team and the provider had a clear plan for the improvement of the hospice and for end of life care of people in the community.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service wasn't completely safe. Staff had systems to ensure medicines were fit for purpose; however these audits were not always acted on.

Staff knew how to keep people safe from abuse. They could identify the signs of abuse and knew the correct procedures to follow if they thought someone was being abused. Staff were recruited effectively and had the skills and training they needed to meet people's need.

People and staff assessed and managed the risk to people. People had the equipment they needed to be cared for safely. People were cared for in a clean and safe environment.

Is the service effective?

Requires Improvement ●

The service was not fully effective. Care plans were personalised and detailed, however there was often too much information in people's care files for staff to easily find the information needed.

People were involved in planning and managing their end of life care. People made decisions of where and how they wanted to be cared for at the end of life. People told us the service was effective and they had access to the care, support and food and drink they needed.

Management supported staff effectively and staff had the skills and professional development they needed to care for people in the hospice.

Is the service caring?

Outstanding ☆

The service was caring. People and their representatives told us the care and support they received was brilliant. People praised all of the staff within the hospice and felt they were always treated with care and respect.

People told us they were at the centre of their care, and made the decisions that they wanted. People's views around end of life care were clearly recorded and respected. Relatives told us the end of life care at the hospice was good.

People's spiritual and religious needs were taken into account and support was provided when required. People, relatives and staff spoke positively about the spiritual support they received.

Is the service responsive?

Good ●

The service was responsive. Staff responded to people's needs and ensured they were comfortable and never left in pain.

People told us there were varied and engaging therapy sessions. The hospice worked well with other agencies to manage their care in the hospice and in their own homes.

Summary of findings

People's views and concerns were listened to and acted upon. The registered manager and senior staff dealt with complaints to find a positive outcome for all involved to ensure people's care needs were maintained.	
Is the service well-led? The service was well-led. The hospice staff had a clear improvement plan for the hospice to provide quality end of life care at Nettlebed, and in the wider community. People, visitors and staff were involved in decisions about the hospice and were asked for feedback. Staff were aware of the vision and values of the provider to provide good quality care and treatment for people at the end of their life.	**Good** ●

Sue Ryder - Nettlebed Hospice

Detailed findings

Background to this inspection

We visited the home on 5 August 2014. We spoke with four of the 10 people who were staying at Sue Ryder - Nettlebed. We also spoke with four people's relatives and friends. We spoke with staff from the hospice which included two doctors, two nurses, three of health care assistants, four domestic workers, the Head of Clinical Services and the registered manager. We looked around Sue Ryder - Nettlebed and observed the way staff interacted with people.

This inspection team consisted of an inspector, a pharmacist inspector, a specialist advisor with a background in nursing 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 care service.

Before the visit we looked at previous inspection reports and notifications that we had received. Services tell us about important events relating to the care they provide using a notification. We also reviewed the Provider Information Return (PIR) from the service. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We last inspected Sue Ryder – Nettlebed on 27 January 2014 and found no concerns.

We looked at eight people's care records including their medicine records and at a range of records about how the hospice was managed. We saw feedback from people who had used the service, and a range of audits.

Following our inspection we spoke with two social care professionals and with five people who received support from Nettlebed in their own homes.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Requires Improvement ●

Is the service safe?

Our findings

People's medicines, including controlled medicines, were stored safely and there was a system for the ordering, receipt and disposal of medicines. The service was visited twice a week by a clinical pharmacist, who provided advice on prescribing and medicines management. There was a system in place for checking expiry dates of medicines but this was not effective as seven medicines were found to be out of date and therefore not suitable for use. There was limited risk that these medicines would be used, however they were still accessible for use.

People received their medicines safely and when they needed them. Staff recorded the actual time medicines were given to people and medicines were always given at the correct time intervals. People's pain medicine was clearly recorded when administered to ensure people were protected from the risks of taking too much medicine.

Staff told us they received training in medicines management and also specialist equipment such as syringe drivers. Their competency for administering medicines was assessed at two yearly intervals. Medicine errors were recorded on a monitoring system to ensure that lessons were learnt and people were protected. All the errors reported had been investigated and actions put in place to prevent them from re-occurring.

The service was safe because people and their relatives felt safe at Nettlebed and were protected from abuse. Everyone knew what to do if they needed help. All felt their needs were responded to promptly. One person described their visit to the hospice as, "It feels like being wrapped in a warm blanket." Another person told us, "I do feel safe here."

People and their representatives were given information about safeguarding and safeguarding information was displayed on wards. Staff had received safeguarding adults training and knew how to raise any concerns with management or with external agencies such as local authorities or the Care Quality Commission (CQC). Staff showed a good understanding of the different forms of abuse and felt confident any concerns they raised would be dealt with effectively.

People were involved in planning and managing the risks associated with their health, care and treatment. One person came to the hospice with a pressure sore. Staff assessed the pressure sore with the person and they planned how to treat the sore and keep the person comfortable and pain free.

No one staying at the hospital was subject to a Deprivation of Liberty Safeguard (DoLS). Deprivation of liberty safeguard is where a person can be deprived of their liberties where it is deemed to be in their best interests or their own safety. The registered manager and Head of Clinical services were both aware of recent court judgements around DoLS. All ten people staying at the hospice had the mental capacity to make decisions about their treatment. Staff and the management of the hospice told us they supported people to make decisions and that all decisions were based around the person and their views.

People and their relatives told us the equipment people needed was available. People described a level of practical support and attention to detail that made them confident about the use of equipment, both in the hospice and in readiness for a return home. We saw equipment was maintained and regular checks were in place to ensure equipment was safe.

There is a plan for this service to move to purpose built accommodation. In the meantime, plans were in place that effectively managed the risks associated with not having enough storage space. For example, there was limited storage for items such as oxygen tanks. Oxygen was stored on the first floor and the registered manager had clear risk assessments to manage this. The registered manager had informed the provider about the risks imposed by the building and these risks were reviewed regularly.

People told us the hospice was always clean and tidy. We saw there were arrangements in place to keep the hospice clean and hygienic. For example, there were dedicated cleaning staff who worked seven days a week. There were hand sanitizers and information about hand cleaning for people to use. Staff had the appropriate training and knowledge about how to protect people from the risk of infection. All staff were aware of the importance of keeping the service clean and demonstrated good knowledge of controlling the spread of infection in accordance with the provider's policies. We saw that all staff used personal protective clothing, including gloves and aprons when needed.

Requires Improvement ●

Is the service safe?

There were enough staff to meet people's needs. The registered manager used a tool to help them determine how many staff were needed, based on people's needs. People and staff told us there was always plenty of staff. One person said staff were always "here in a flash."

Records relating to recruitment showed that the relevant checks had been completed before staff worked unsupervised at the home. These included employment references and disclosure and barring checks to ensure staff were of good character. In addition staff received induction training and a period of shadowing with more experienced staff.

Requires Improvement ●

Is the service effective?

Our findings

We saw that care records were not always in order which made it difficult for staff to find current information. One family member told us they had to intervene to make sure new staff understood their relative's needs as they thought notes were out of place. The relative discussed their concern with staff and the doctor who were effective and ensured there was no disruption to the person's treatment. We raised these concerns with the registered manager who told us they were looking at changes to the paperwork. We also saw that these concerns had been identified during an internal quality audit by the provider in February 2014 but no action had yet been taken.

People, their relatives and friends spoke positively about the hospice and the care and support their loved ones received. People told us: "Absolutely brilliant. Without them I don't know what I would have done"; "They have given me so much. I appreciate it so much." A relative told us, "It was a revelation. They are there to help you manage. They helped us enormously, showed us a way forward to maintain quality of life and they gave immense support."

People were involved in the assessment of their needs and how their needs were met. People were asked for their views around their care and what they wanted the care to achieve. People's care plans included risk assessments for pressure area care, falls, personal safety, pain relief, mobility and nutrition. All assessment plans were written with the person they related to. These plans documented and incorporated their preferences. One person had shared with staff what was important to them in relation to their end of life care. Staff had recorded this and worked with the person to accommodate those wishes. This included being cared for at home and being as independent as possible.

People received medical support from in house doctors and had confidence in their skills. People and staff told us there were good links with local hospitals and GPs to ensure people's medical needs were met whether they were staying at the hospice or receiving support in their own homes. People and family members felt they were in control of medical decisions that related to them. For example, one person was advised they could have a Percutaneous Endoscopic Gastromy (PEG) (a means of receiving nutrition through the stomach wall when people cannot take food). The person had declined this form of support and staff supported them in other ways.

Staff were trained to provide specialist end of life care for people. All the staff including doctors, nurses, healthcare assistants and domestic workers had completed mandatory training required by the provider as being relevant to their roles and responsibilities. Examples of subjects covered during this training included palliative care, moving and handling, equality and diversity, health and safety awareness, infection control and Mental Capacity Act 2005. Nurses completed competency-based assessments around medicines every two years. One member of staff said, "There is always lots of training and we can request any additional training if we need."

Staff were supported through supervisions (meetings with a manager) and appraisals. All staff confirmed they had supervisions and were able to discuss any concerns and any development needs. One staff member told us, "It's important. It gives us a confidential way of raising any issues."

Some people had special dietary needs and preferences. These were recorded as part of their assessment and this information was available for kitchen and care staff. People told us there was plenty of choice in relation to food and they could request other options if they did not like the day's menu. One person appreciated being able to choose portion sizes and said this suited their appetite, and helped them to eat healthily as they found a large plateful of food overwhelming. One person's friend told us that, due to the encouragement of staff and menu choices, their friend had been enjoying their food and their appetite had increased at the hospice. People told us mealtimes were pleasant and they were supported and treated with respect. Some people were at risk of losing weight and of dehydration. Systems were in place to monitor and manage these risks. Special care was being taken during the time of our inspection, due to the hot weather, to ensure adequate fluids were consumed.

People saw dietary and nutritional specialists if required. The home contacted dieticians and speech and language therapists if they had concerns over people's nutritional needs. One person had been referred to speech and language therapists for guidance and staff were following this guidance.

People and their relatives and friends appreciated the setting of the hospice. Two people mentioned how much they enjoyed the view from their rooms and seeing people using the gardens. Another person was very interested in

Requires Improvement ●

Is the service effective?

the history of the building. People were involved with proposed changes to the building. For example, people and staff told us how they were involved in choosing new chairs and chair covers for the day therapy room. People, the registered manager, and staff told us the provider was looking to move the hospice to purpose built accommodation. This move had been proposed as the provider was limited to the changes that could be made to the building.

Outstanding ☆

Is the service caring?

Our findings

People, their families and friends told us they were happy with the care and support they received at the hospice and felt they were treated with dignity and respect by hospice staff. People told us: “absolutely brilliant”, “incredible kindness”, “absolutely fantastic”; “marvellous”; “some staff have been there so long; they love what they do; they are very special and become friends.” One person stated (with reference to being treated with dignity and respect): “absolutely in every way. I can’t say anything wrong about it”.

Friends and relatives of people said how much they appreciated the open visiting times and the offer of tea and cakes when visiting. We saw that visitors were welcomed by staff and, when people wanted privacy to speak with their visitors, this was respected.

Staff treated people with dignity and respect. We were told that one member of staff was the dignity lead for the home. Staff told us information on dignity and promoting people’s independence was available for all staff. We saw that staff were respectful and compassionate to people throughout our visit. A volunteer, who supported weekly therapy sessions, described the interaction between staff and those who attended as “it’s lovely” and “they have a wonderful supporting role – it works a treat.”

People told us they were at the centre of their care and their personal views were respected. Care plans reflected the staff attitude of placing the person at the centre of the service. Records showed what was important to each person receiving support from hospice staff and was treated as important information by staff. For example, staff had recorded information about people’s family life, employment and religious beliefs.

One family member felt fully involved in planning their relative’s care and praised hospice staff for ensuring that their relative was the “key person”. They said there was never a sense of “talking over” their relative, however ill they were. They stated how highly they regarded this as it “protects the patient.”

People made decisions about confidentiality. People’s assessments showed who was involved in the person’s care and who could be given information about that person.

People were asked for their views around their social and family needs. One person had a family dog which they wished to see. We saw records that staff at the hospice had encouraged and supported this to take place.

One relative described how their relative had initially been reluctant to attend the hospice. However they had visited the hospice before staying and this had reassured them. The family member said their relative “emerged like a new woman” after their admission and had been overwhelmed by the kindness and care of staff, approaching them as an individual and asking “what can we do for you?.”

People felt their spiritual and religious needs were met and respected by staff. We spoke with the hospice’s chaplain who told us, “I am here for all faith and none. I try and meet every patient that is admitted here. I build relationships with people and support them to follow their faith, or meet their spiritual needs if they do not have a faith.” One person had documented they were not religious and did not wish to see the chaplain about religious needs. Staff told us this decision was respected. A room was set aside for use as a chapel. People, their relatives and friends could use this room as a quiet space. A family member of a deceased inpatient described how the chaplain had been “wonderful with her” although she had “no religion”.

One person using day therapy described how helpful staff had been on a day when they “had a bit of a wobble.” Staff contacted the doctor and the person was “supported with incredible kindness”. They also said, “You can always ask them a question. They have given me so much. I appreciate it so much.”

People felt the overall experience of attending these sessions was positive. One user of day therapy and respite admission described the support they had when at home. They talked about phases when they had been depressed. They told us they contacted the hospice and were given immediate, effective support. As a result of the call the person told us the chaplain came to visit them which they found a great comfort.

People were supported at the end of their life. One family member of a person, who recently passed away, praised the end of life care their relative received. They stated their relative “died most beautifully”. They felt they had been kept well informed by hospice staff about the different stages of their relative’s condition. They said that staff “could not have been more sensitive and kind.”

Outstanding ☆

Is the service caring?

People's views about their end of life care were recorded. People's care records showed how people wanted to spend their final days and the people they wished to have involved in their care. For example one person wished to stay at their own home or the Nettlebed hospice at the end of their life. Spiritual and religious needs at the end of life were recorded and acted upon. The chaplain told us, "I am here if I am needed when someone passes. If someone wants ministry at point of death I am available or people can also have their own support."

People were asked for their views on Do Not Attempt Cardiopulmonary Resuscitation orders (DNACPR). We saw everyone had a completed DNACPR and that one person wished to be resuscitated. Staff were aware of this need and told us nursing staff had the training and skills to meet this person's needs.

Good ●

Is the service responsive?

Our findings

People told us they were at the centre of their care. People's views were recorded and they were fully involved in the planning of their care. Where a person was unable to fully contribute in that planning, their family or friends were involved. Each person had a life plan which described their objectives and outcomes. When people's needs or views changed these were recorded. One person told us, "Decisions are mine". Another person told us, "I am absolutely involved in my care."

Nursing staff and doctor's ensured people were comfortable and pain free. People and relatives praised the responsiveness of doctors, nursing and care staff. They described the careful management and regular review of medicines. When people were in pain staff responded quickly to ensure people's comfort was maintained and the pain was brought under control. Records showed that staff adjusted their medicine to achieve a balance of pain management without making people drowsy or tired. People told us they were never left in pain and staff were responsive to their needs.

Hospice staff acted quickly and were able to identify when people's needs changed. For example one person was receiving support in the community. Hospice staff and the person's family were concerned the person was at risk of neglect and isolation. A member of staff met with the person and discussed options around their care. Records showed the person wished to stay at home and hospice staff worked with them and a local domiciliary care agency to ensure the person's health needs were met in the community.

Staff respected and acted on people's personal preferences and circumstances. For example, one person said how staff were aware that they did not like being "shut in", and had asked for their door to be kept open. We saw this happened throughout our visit. They also told us when they wanted a shower; they were offered the choice of a bathroom which had more space and where they felt more comfortable. One person had shared with staff what was important to them in relation to their end of life care. Staff had recorded this and worked with the person to accommodate those wishes. This included being cared for at home and being as independent as possible.

People told us they enjoyed therapy sessions held at the hospice. Therapy sessions involved a range of activities which were appreciated by people who all found different aspects of the sessions engaging. People described sessions such as relaxation techniques, reflexology, one-to-one support, memory boxes, games and quizzes or chatting over tea and biscuits. One person who attended a nurse-led clinic described how helpful the sessions were. They said the sessions reduced the sense of isolation they felt. Another person told us they enjoyed all the activities and said, "The whole thing is so comforting." One relative described day therapy as "amazing" and praised the help the family received from hospice staff. They said it helped to link communications between different health care professionals and "sort out problems".

People received consistent and co-ordinated care. The service worked with other agencies to ensure that people received the support they needed when they left the hospice to go home. Records showed the hospice worked with local domiciliary care agencies to care for people in their homes. Multi-agency meetings were frequently conducted with people at the centre of any decision making processes.

Staff gained consent from people about the care, treatment and support they received. Staff told us that decisions made for people who could not give consent were decisions made in their best interests. Care records contained information detailing where consent had been given and which people they wished to be involved in the planning of their care. We saw examples where people had signed to say they consented to medicines being administered and to receive care from hospice staff.

People and their relatives were asked for their views about the hospice through surveys and questionnaires. When suggestions for improvement had been made, it was clear action had been taken by the provider. Where action was unable to be made, such as changes to the building, the registered manager explained this to people. Records of meetings between people and the registered manager were recorded and positive outcomes could clearly be identified.

Good ●

Is the service well-led?

Our findings

The provider had a clear vision of what it was striving to achieve and what it aimed to provide to people and staff. These goals were in the service's statement of purpose, policies, procedures and information provided to staff, people and their relatives. Staff described the service's vision as giving people the care they wanted by focusing on the person, their strengths, characteristics, preferences and aspirations. We observed that staff respected people's preferences and understood and documented their strengths in care plans. One staff member said, "We support people in the way they want to be supported."

Staff told us they utilised the Gold Standards Framework around end of life care to ensure people received the support and care they wanted and needed. The management of the hospice met with local clinical commissioning groups to discuss best practice around end of life care and were working with them around developing an end of life care model for 2015 and 2016. Staff explained the aim was to help drive the performance of hospice services for people in the area.

Good communication between staff was evident from staff meeting records which showed that the same information was consistently shared with all staff of the hospice. This openness extended to people and their visitors. People told us the service had been open about the challenges they faced especially in relation to the proposed move of the hospice and changes to the management structure of the hospice.

People and visitors had the opportunity and were encouraged to get involved with the hospice. A member of the family support group stated that "everyone has a voice". Regular meetings were held for people who stayed at the hospice or attended therapy groups. People were involved in discussions about changes to the hospice and the impact these changes had on the hospice and people. Actions were noted at the end of each meeting. These actions were followed up by the registered manager and changes made. For example, discussions were had around recent filming in the hospice. People felt some of the noise from the filming was inappropriate in relation to a hospice setting. The registered manager listened to these concerns and now any requests to film at the hospice would be discussed with people and staff before filming took place.

There were strong links with other agencies as the provider wanted to ensure people received co-ordinated care. They had plans in place to do this which included a community engagement plan. Meetings had been arranged with the Heart Failure Team to explore joint working, district nurses to develop end of life care education, and also plans to involve people from the local community in the hospice. These links were being established to provide people with consistent and co-ordinated care.

Training for staff was designed around meeting people's diverse needs. There was a detailed education and training plan for all staff and volunteers. This included plans for mandatory training and professional development. Additional areas such as communication skills, clinical supervisions, management and leadership and mentorship were also planned. This linked to areas of nationally recognised best practice such as the Royal College of Nursing leadership programme. Training needs of staff were identified by the registered manager and plans were in place for on-going clinical training and dementia training to ensure staff had the skills they need to effectively meet people's needs.

Staff had clearly defined roles and they understood their responsibilities in ensuring the service met the desired goals for people. The leadership structure was understood by staff and they told us the hospice management was skilled, supportive and provided them with clear direction and a sense of value. Staff told us managers were visible, accessible and responsive to any concerns staff may have raised.

Observations and accounts from managers demonstrated a high level of support for staff and an understanding of the pressures of their day-to-day routine. Areas set aside for staff relaxation were thoughtfully sited and designed. Managers said compassionate leave was a significant reason for regular staff absence in 2014. Staff felt it was a good thing the emotional impact of their job was recognised by management.

There was a quality improvement plan in place for the hospice. This covered areas for growth and improvement as well as recognising achievements. Clear plans were in place around community development, staff education and the views of people. Part of the improvement plan was to further develop community development, staff education and the quality of care for people. Annual surveys were used to inform the development plan. In

Good ●

Is the service well-led?

addition, people who had stayed at the hospice were asked for their feedback after their stay. Records showed that this feedback and people's views informed the on-going development of this service. A recent survey of staff showed they were satisfied with the support from the hospice management and this had improved since the 2013 survey. It also showed the positive results had meant the hospice had achieved "one to watch" accreditation (a scheme which denotes it as a good place to work).

The provider monitored the quality of service provided at the hospice. The acting head of clinical quality and quality manager for Sue Ryder visited the home in February 2014 to assess the quality of the service as part of a "deep dive" quality visit. A report was written which related to best practice from the High Quality Care Metrics for Nursing. This audit looked at incident reporting, people's and staff experience. Where a recommendation was made, such as ensuring all people at high risk of falls had a corresponding care plan, action had been taken. The report also noted areas of commendation which included congratulations to the team for working together and creating a caring environment.