

Isabel Hospice Limited







Isabel Hospice

Inspection report

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Ratings

Overall rating for this service	Good	
Is the service safe?	Good	
Is the service effective?	Good	
Is the service caring?	Good	
Is the service responsive?	Good	
Is the service well-led?	Good	

Overall summary

This inspection took place 25 and 26 January 2016 and was unannounced.

Isabel Hospice provides care for people with life limiting illnesses through its inpatient unit, hospice at home service, day care unit and its specialist community palliative nursing care service.

There was a manager in place who was in the process of registering with the Care Quality Commission (CQC) to be the registered manager. 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.

People felt safe. Staff had received training to enable them to recognise signs and symptoms of abuse and how to report them. People had risk assessments in place to enable them to be as independent as they could be.

Summary of findings

There were sufficient staff, with the correct skill mix, on duty to support people with their needs. Effective recruitment processes were in place and followed by the service.

Medicines, including controlled medicines, were managed safely. The processes in place ensured that the administration and handling of medicines was suitable for the people who used the service.

Staff received a comprehensive induction process and ongoing training. They were well supported by the management team and had regular one to one time for supervision. Staff had attended a variety of training to ensure they were able to provide care based on current practice when supporting people.

Staff gained consent before supporting people and ensured their choices were acted on. People were supported to make decisions about all aspects of their life; this was underpinned by the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff were knowledgeable of this guidance and correct processes were in place to protect people.

People were able to make choices about the food and drink they had, and staff gave support when required.

People were supported to access a variety of health professionals when required.

Staff provided care and support in a caring and meaningful way. They knew the people who used the service well. People and relatives, where appropriate, were involved in the planning of their care and support.

People's privacy and dignity was maintained at all times.

People were supported to follow their interests and join in activities.

A complaints procedure was in place and accessible to all. People knew how to complain. Effective quality monitoring systems were in place. A variety of audits were carried out and used to drive improvement.

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?

The service was safe.

Staff were knowledgeable about protecting people from harm and abuse.

There were enough trained staff to support people with their needs.

Staff had been recruited using a robust recruitment process.

Systems were in place for the safe management of medicines.

Good



Is the service effective?

The service was effective.

Staff had attended a variety of training to keep their skills up to date and were supported with regular supervision.

People could make choices about their food and drink and were provided with support when required.

People had access to health care professionals to ensure they received effective care or treatment.

Good



Is the service caring?

The service was caring.

People were able to make decisions about their daily activities.

Staff treated people with kindness and compassion.

People were treated with dignity and respect, and had the privacy they required.

Good



Is the service responsive?

The service was responsive.

Care and support plans were personalised and reflected people's individual requirements.

People and their relatives were involved in decisions regarding their care and support needs.

There was a complaints system in place. People were aware of this.

Good



Is the service well-led?

The service was well led.

People and their relatives knew the manager and were able to see her when required.

People and their relatives were asked for, and gave, feedback which was acted on.

Quality monitoring systems were in place.

Good



Isabel 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.

This inspection took place on 25 and 26 January 2016 and was unannounced.

The inspection was carried out by a team which included two inspectors, two specialist advisers, a pharmacy inspector 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. The specialist advisers had experience and additional knowledge in pressure care and end of life care.

Prior to this inspection the Care Quality Commission (CQC) received information of concern relating to the provision of

care and management of pressure ulcers at the service. We reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. We reviewed this information to help focus our planning and determine what areas we needed to look at during our inspection.

During our inspection we observed how staff interacted with people who used the service.

We spoke with four people who used the service and seven relatives. We also spoke with the director of clinical services, team leader for clinical governance, a consultant, a doctor, a pharmacist, a senior sister, three nurses, a physiotherapist, lead nurse for community care, the hospice at home lead and volunteer staff.

We reviewed four people's care records to ensure they were reflective of people's current needs, three medication records, eight staff files and additional records relating to the management of the service, such as quality audits.

Is the service safe?

Our findings

People told us they felt safe. One person said, “I am safe here, there are no worries about that.” A relative said, “We have no concerns.”

Staff and volunteers told us they had received safeguarding training and were able to describe what could be classed as abuse. They were also able to tell us what would alert them to the possibility that someone had been or were being abused. One staff member told us, “We have good training about safeguarding, including safeguarding children.” Staff were able to explain their reporting policy if this occurred. There were safeguarding notices in the building giving information on how to report abuse. The service had two safeguarding leads and a person designated as the child protection lead, who kept up to date on legislation and knew how to report issues. The provider had a whistle blowing policy. Staff we spoke with were able to describe this to us and told us they would use it if necessary to ensure people were kept safe and secure. This showed that there were systems in place to protect people from abuse.

Staff told us that everyone had risk assessments within their care records. We saw documentation within people’s care records which had been developed with input from the person themselves, the staff team and other health care professionals where appropriate. These included; nutrition, bed rails and pain. There were risk assessments in place for the environment, including working in the kitchen, infection control and cleaning.

The senior sister explained the emergency evacuation procedures. We saw documentation for a major incident procedure and contingency plans in the event of complete evacuation. This would ensure that people would still be cared for as they would be transferred to a safe place.

Staff told us that accidents and incidents were reported and recorded and they were given feedback if necessary about anything that could have been done to prevent them. Accidents, incidents and near misses were audited regularly, from this action plans had been developed if required. We saw documentation of correctly recorded accidents and incidents.

People told us there were enough staff on duty to provide the care they required. Staff also told us there were enough of them and they were supported by a large number of

volunteers. One new staff member told us that the good care people received was enabled by good staffing numbers. Staffing rotas we looked at showed a good skill mix of staffing levels on all shifts. Staff did not appear rushed and were able to spend quality time with people. The director of clinical services told us they had recently reviewed and remodelled the rotas to ensure the correct number of staff were on duty at the appropriate times. They used the European White Paper and Hospice UK guidance to determine staffing numbers

Staff and volunteers told us that they had not been allowed to start working until their checks had been completed and they had done some training. This was for both employed and volunteer staff. The provider had a recruitment policy which we were told must be followed. This included appropriate checks, for example; two references, proof of identity and Disclosure and Barring Service (DBS) check. Records we saw confirmed these checks had taken place.

People received their medicines as prescribed by in-house doctors on prescription charts. We observed the preparation and administration of a syringe driver containing a pain relieving medicine to a person. A nursing staff member ensured that the preparation was double-checked by another staff, correctly completed the controlled drugs register and promptly administered the medicine in a caring way to the person. We received good feedback from the person’s relatives, who highly commended the service and confirmed that the person was given their medicines accurately and on time. People’s medicines were supplied via stock medicines or on a named patient basis from the hospital pharmacy.

Medicines were stored, given to people and disposed of safely, in line with current regulations and guidance. Fridge and room temperatures in the treatment room were audited daily, registers were accurately completed and there was a robust procedure in place for the disposal of unwanted medicines, including people’s own medicines if they chose. We saw evidence of this documented.

At the time of inspection no one had their medicines administered covertly, self-administered their medicines or had homely remedies. A nursing member of staff showed us the process and procedures of what to do should one of these above scenarios occur, with regards to ensuring people’s safety in the use of medicines. For example, we were shown a risk-assessment template should anyone

Is the service safe?

wish to self-administer their medicines, which included factors such as if suitable quantities were available and if the person was physically able to administer their own medicines.

We found that the service had a robust process of shared learning from medicines incidents. For example, we saw evidence of incidents that were reported. These incidents were then investigated by a clinical lead and learning was

disseminated via weekly clinical meetings or a monthly newsletter. A nursing staff member explained that all staff members were encouraged to report incidents as a way of learning from mistakes that had happened, to ensure they didn't happen again. This assured us that there is a culture of openness and transparency when it came to the governance of medicines and people's safety, which was in line with the provider's policy.

Is the service effective?

Our findings

People told us that they felt the care they received was good and was provided by well trained staff. One person said, “The staff know what they are doing.”

Staff told us they received a variety of training including; health and safety, infection control and safeguarding, also training more specific to their job role. For example, they had also received training in; medication, syringe drivers and catheter care. One staff member said, “The training is very good.” Another told us, “We get a lot of training, it is important we keep up to date.” We saw the training matrix which showed which training had been completed and when it was next due. It covered both mandatory and additional training. We were told that volunteers in the service received the same training as the staff where it was required. One volunteer we spoke with confirmed this to be the case, they said, “I had a four day initial training followed by two days refresher.” This ensured that people using the service were being cared for by staff and volunteers who were up to date with their knowledge and skills.

The hospice was supporting nurses to understand and prepare for revalidation with the Nursing and Midwifery Council (NMC).

The director of clinical services told us that new staff must follow the provider’s induction programme. This was signed off by a senior member of staff and checked by the Human Resources (HR) department before anyone could be put on the rota and work independently. Staff we spoke with and documentation we saw confirmed this.

Staff told us they got regular supervision and appraisals. One staff member said, “We get really good support.” One staff member told us, “We can speak to any of the senior or management staff at any time; everyone is available for us if we need them.” The HR department told us that they were preparing the forms for annual appraisals. There were copies of all supervision and appraisals in staff files.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack 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.

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).

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. There was no one being deprived of their liberty and people were free to come and go as they pleased. People were supported to make decisions and the MCA would have been used if required. Staff discussed one persons capacity at the handover meeting and followed correct procedures, showing they had a good understanding of the subject.

People consented to their care being provided. One person told us, “Staff always ask for consent.” We observed staff gain consent to enter peoples rooms and before any activity, for example; assisting with personal care, administration of medication and speaking with an inspector. Within care records we saw that people had signed for consent to care and support.

Staff told us that some people had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) in place. One staff member said, “The doctors discuss those with the person and their family.” They told us they were discussed in handover to keep up to date. Documentation we saw confirmed they had been completed correctly.

People told us that the food was good and alternatives were always offered. One person said, “There’s a good choice and quality.” Another said, “The food is excellent.” A relative said, “Since she has been here she is getting three meals a day and if she wants something special they will get it for her.” We spoke to the chef who told us they involved people in menu planning. They met with them on a regular basis to ensure people were happy with the meals provided and to enable changes to be made. All of the food was freshly prepared on site, including cakes and biscuits, by the chefs. They explained this enabled them to fortify most foods to help with people’s nutrition. Catering staff told us they knew if anyone required a specialist diet, the dietician would speak to them and they would devise a menu which was appropriate. We observed lunch being served, alternatives were available and offered. People who required assistance were supported by staff in a dignified manner. Drinks and snacks were available at all times.

Is the service effective?

People were able to access a variety of healthcare services. The service had doctors and therapists on site to assist people immediately. The service had their own specialist physiotherapists. We spoke to one of the physiotherapists who told us that she was able to start to work with people when they needed the support. A fully equipped therapy room had been set up to enable this. There was also a

therapy team which consisted of; occupational therapist, complementary therapist lymphoedema therapist and a therapy assistant. This enabled people to access services immediately they were required. Within people's records we saw evidence of input from doctors, specialists, psychologist, dietician and the SALT (Speech and Language Therapy) team.

Is the service caring?

Our findings

All people and visitors spoken with were positive about the care provided by the hospice and spoke of the friendliness, approachability and empathy of staff. People said that staff treated them with kindness and compassion. One person said, “The staff always seem as if they want to be here.” Another said, “You can ask them anything and they will try and get anything you need.” A relative said their relatives care had been ‘superb’.

It was evident from our observations that staff knew people well and they were treated with kindness. For example; we found that one nurse was particularly attentive and listened to what one person wanted, she held their hand and was reassuring. Through this action the nurse conveyed that they cared about the person.

One person said the nurses were friendly and professional and that their doctor had, ‘Taken me ten steps forward’. They told us, “It is obvious I am dying, but whatever time I have got left she has made me feel better.”

We saw positive interactions between staff, people and their visitors throughout our inspection. We observed people chatting with staff who gave them the time and support required. People were given the time they needed to talk about whatever they wanted. Staff knew when to stay or when to leave people alone or with relatives.

The service had a chaplaincy service available on site. The chaplaincy service was available for both the person receiving care and family and friends, and could be called on at any time. A visiting minister described the hospice as, ‘Providing quiet, reassuring care to families who are worried; they give reassurance that each person is important and that they will be cared for until they die.’

People told us that they had been involved in the planning and management of their care, along with their families or representative, and that this was ongoing. Plans we looked at contained information regarding advanced decisions. People’s wishes had been documented.

We observed staff respecting people’s wishes, including; going outside for a cigarette and refusing personal care at that time, but responding immediately when the person changed their mind.

The service had access to advocacy services for people if they were required. At the time of our inspection no one was using the services of an advocate.

People who used the service and relatives spoke positively about privacy and dignity. One person said, “Staff always knock on my door, even though it is open, and check it is ok to come in.” We observed staff acknowledging notices on people’s doors, for example, do not disturb.

We observed positive respectful behaviour between staff. One staff member said, “We are one big happy team, it does not matter who employs you, we all work together.”

People told us that they could have visitors at any time, whenever they wanted them. A relative told us they stayed as long as they wanted when they visited and staff made sure they had meals and drinks. We observed staff supporting visitors and offering meals.

There were two self-contained flats within the service which were for people to use to stay at the hospice to be close to their relatives.

Is the service responsive?

Our findings

People told us they had been involved in the development of their care or treatment plan. One person said, "I know exactly what I want, it has been recorded and staff are doing it."

Staff told us that a number of people were known to them before admissions, and care and support plans were already in place. One staff member told us that the nurses and doctors liaised closely to address patients' needs and felt this led to good patient care. They also told us that when people were admitted, one person completed their initial documentation, which was called dual clerking. This meant that people were not asked the same questions twice by the nursing team and the doctors. When people came in the care or treatment plans were discussed and expanded to ensure they were person centred and showed exactly how people wanted to be cared for. People told us, and documents confirmed, this had taken place.

Staff told us that care or treatment plan input was from a variety of sources including; the person's GP, consultants, physiotherapists, the person themselves, family or representatives, hospice at home service and the chaplain. They included goals for discharge to home or other types of care if appropriate. Within people's care plans were end of life plans if these were appropriate. They had been discussed with the person and family and were detailed to enable the person's wishes to be carried out.

Staff told us that they had 24 hour access to any extra support, which may be required if a person's condition changed rapidly. This support was also available to people receiving Hospice at Home care.

We were told of a Specialist Palliative Care Telephone Advice Line which the hospice had set up which was available seven days a week. This is a specific telephone line which would be answered by a nurse at any time. It was used by local doctors, district nurses, people who had been discharged or using the Hospice at Home service or their relatives. This was to give support or specialist advice especially around palliative care. Documentation of all calls was kept and showed it was used effectively and had prevented possible hospital admission.

The service also has a day service, a Hospice at Home service and Clinical Nurse Specialists working in the community. There is also a Fatigue And Breathlessness

(FAB) service at an outreach centre. Staff told us that some people were admitted to the hospice short term to have their medication reviewed and balanced, especially pain relief. Once this had been achieved, they were then able to return home where care would once again be lead by the clinical nurse specialist and community doctor. Further admissions to the in patient unit could be facilitated at any time they were required.

The Hospice at Home service covered a large area and enabled people to stay at home and receive care and treatment. They provided a specialist palliative care service which offered nursing care including personal care and symptom control, as well as emotional support. They had a team of volunteers that offered respite sits to carers and support with personal care. The Hospice at Home team worked closely with people's Clinical Nurse Specialist, GP and District Nursing Team.

The service also offered a bereavement service and family support. The team consisted of professional and volunteer staff who had been specifically trained in counselling, family work and palliative care. They offered support to families and individuals who were facing serious illness or bereavement; this could be in groups or one to one.

Throughout our inspection, we observed that staff were not rushed and spent time with people and their relatives. For example, chatting or comforting people and relatives. Care offered was person centred and individual to each person.

People were aware of how to make a complaint if needed. All of the people spoken to said they would complain if they felt they had to, but they had no complaints to make. The director of clinical services told us that all complaints were looked at and sent to the appropriate manager to investigate. Every complainant was invited in to discuss the issue. Documentation seen showed this had happened and complaints had been resolved. The complaints policy was on the notice board and in the information booklet given to people.

There was a notice board with the feedback procedure on it, this explained how people could give feedback. There were also results of the last survey. The survey had been sent out to people who had used the service or their relatives. The director of clinical services told us that they were collated and results reported on a quarterly basis, due

Is the service responsive?

to the turnover of people using the service. She explained that any negative comments or suggestions would be looked at and actioned if necessary. Results were seen which were all positive.

Is the service well-led?

Our findings

Staff said that there was an open culture, they could speak with the manager about anything and they would be listened to. They did comment that there had been a lot of management changes, especially over the last six months but said that things had begun to settle down and changes were positive. These changes had included additional staff being recruited.

Staff told us that they received support from the manager and senior staff. One staff member told us, “We can speak to anyone, everyone is open and helpful.” Another said, “I love working here.”

The current leadership team that we met were all quite newly appointed. We spoke at length with the director of clinical services and found she had a clear vision and understanding of what needed to happen to move the service forward. She explained some of the things they wanted to do. These included; increasing the drop in service, put together a clinical leadership group and work with schools and youth groups to inform them of the hospice work. We found that staff had been consulted about the development and changes the manager had planned.

There was a manager in post who was in the process of submitting their registration with CQC. People told us various management staff were available to speak with at any time. During our inspection we observed the manager, sister in charge and team leader for clinical governance chatting with staff, visitors and people who used the service. It was obvious from our observations that the relationship between them and the staff was open and respectful.

On day one of our inspection we found that incidents of pressure care were not being photographed or measured accurately. This did not have an impact on the care people were receiving. Pressure care was being recorded and people were receiving appropriate treatment. We spoke at length with the management team. On day two of our inspection new procedures had been put in place to photograph and measure the pressure area. Although the

original issue should have been picked up in quality assurance audits, we saw that the service was responsive and acted accordingly. Pressure care recording had not been included in the quality monitoring process, on day two of the inspection we were told it would now be added to ensure there was not a recurrence.

Information held by CQC showed that we had received all required notifications. A notification is information about important events which the service is required to send us by law in a timely way.

The hospice had a clear system in place to monitor incidents. Each week any incidents from the previous week were discussed in a multi disciplinary meeting. We sat in one meeting to see what matters were discussed and actions taken. We found that issues of all levels were able to be raised, wherever a matter needed attention and a solution. This included a matter about thermostats on a radiator and clinical issues where people could have been put at risk or injured. Actions were decided, noted, delegated to a specific person to resolve, but also learning logs were created to share with other relevant staff to learn from the incident and prevent similar occurrences.

We followed through on some of these examples and found that actions had been taken. For example an issue relating to medicine was resolved and our pharmacy inspector was able to confirm that good procedures were in place to prevent a similar incident. We also saw that where staff had been asked to cascade information in clinical settings this had occurred as it was recorded in meeting minutes and staff were able to tell us about learning from events. Part of development plans was to have a new centralised computer system that catches all incidents so that these are recorded and automatically added to the correct meeting agendas and the correct people would be informed. This new format would also explore the duty of candour as part of this incident response process.

The team leader for clinical governance told us that regular staff meetings had been held. Staff and documentation confirmed this. There was also a board of trustees which met on a regular basis.