Care Quality Commission

Sue Ryder

# Sue Ryder - Thorpe Hall

## 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

Sue Ryder - Thorpe Hall is a 20 bed hospice located on the outskirts of Peterborough city centre. It is registered to provide diagnostic screening procedures, transport services, triage and medical advice provided remotely and treatment of disease, disorder and injury. The hospice also provides accommodation with a specialist palliative care service for those people living with or affected by serious illness. An in-patient service and day centre to adults is also provided. The service is currently developing a 'hospice at home' service to provide care to people in a home setting.

Accommodation at the hospice consists of rooms for two to three people with separate communal bathrooms. There are internal and external communal areas, including lounge areas, a chapel which can also be used as a multi faith room, garden, coffee shop and shop for people and their visitors to use.

This unannounced inspection was carried out on 22 May 2015. On the day of the inspection there were 16 people accommodated at the hospice. At our previous inspection on 29 August 2013 the provider was meeting all of the regulations that we assessed.

There was a registered manager in place. They had been in the role of registered manager since 04 December 2014. A registered manager is a person who has registered with the Care Quality Commission to manage

# Summary of findings

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.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and report on what we find. There were systems in place to assess people's capacity for decision making and, where appropriate, applications would be made to the authorising agencies for people who needed these safeguards.

People and their relatives were happy with the service provided by the hospice. Staff treated people and their relatives with kindness and compassion, whilst delivering care and treatment in an unrushed manner.

People's wishes and preferences, including end of life wishes, were recorded within the care records as guidance for staff. Staff only commenced care for people if they could safely meet their needs. Staff demonstrated a good understanding of the wishes, including cultural and religious needs of people with an end of life illness.

There were a sufficient number of staff and volunteers in all areas of the service. Safety checks were undertaken on staff and volunteers before they commenced work at the service to ensure that they were of good character. Staff were aware of their responsibility to report any concerns around poor care and treatment. Staff were trained to provide effective care which met people's individual care and support needs. They were supported by the management to maintain and develop their skills through '121' supervision, competency checks and a meeting to set and agree personal development and training objectives.

Individual health risks to people were identified by staff and plans were put into place to minimise these risks. People were provided with adequate amounts of food and drink to meet their hydration and nutrition needs. The service worked with other health and social care providers to make sure that people's health, care and support needs were supported and met. There were arrangements in place for the safe management, administration and storage of people's prescribed medicines.

People were supported to raise any suggestions or concerns that they might have had with staff and the management team. Any issues raised were actioned by management to improve the service.

There was an on-going quality monitoring process in place to monitor the quality of support provided for people and identify areas of improvement required within the service.

# 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?

**Good** ●

The service was safe.

People's health, care and support needs were met by a sufficient number of staff and volunteers. Staff and volunteers were recruited safely and trained to meet people's care and support needs.

Systems were in place to support people to be cared for safely and to make sure that any identified risks were reduced. Staff were aware of their responsibility to report any safeguarding concerns.

People were given their medicines as prescribed and medicines were stored, recorded, administered and disposed of safely.

### Is the service effective?

**Good** ●

The service was effective.

There were systems in place to assess people's capacity for decision making and consent to treatment.

Staff received training and regular supervisions to review their performance.

People's care records were regularly reviewed and staff worked well with other health and social care professionals to ensure that they met people's current health, care and support needs.

### Is the service caring?

**Good** ●

The service was caring.

Staff were caring and compassionate in the way that they supported and engaged with people.

People were involved in decisions about their care and treatment.

People's privacy and dignity were respected by staff.

### Is the service responsive?

**Good** ●

The service was responsive.

Management had listened and acted on the views of people and their relatives.

People's care and support needs were assessed, planned and evaluated. People's individual needs and wishes were documented clearly and met.

People were supported to continue their interests where appropriate and activities such as complementary therapy were made available to people.

### Is the service well-led?

**Good** ●

The service was well-led.

There was a registered manager in place.

People, their family, and staff were asked to feedback on the quality of the service provided through surveys.

# Summary of findings

There was a quality monitoring process in place to identify any areas of improvement required within the hospice. Plans were in place to act upon any improvements identified.

# Sue Ryder - Thorpe Hall

## 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 22 May 2015, was unannounced and was completed by an inspector and a specialist advisor. The specialist advisor had experience of working in palliative care settings.

Prior to our inspection we reviewed the provider's information return (PIR). This is information we asked the provider to send to us to show what they are doing well and the improvements they planned to make in the service. We also looked at information that we held about the service including information received and notifications. Notifications are information on important events that happen in the service that the provider is required to notify us about by law. We also received feedback about the service from a representative from the Cambridge and Peterborough Continuing Health Care team to help with our inspection planning.

We observed how the staff interacted with people who used the service. We spoke with two people who used the service and three relatives. We also spoke with the quality and effectiveness manager, senior sister, three staff nurses, two auxiliary nurses, two volunteers, chaplaincy lead, trainee GP, doctor, day services manager, cook and trainee cook and a visiting professional from a care home.

We looked at three people's care records and we looked at the systems for monitoring staff supervisions, appraisals and training and four staff files. We looked at other documentation such as quality monitoring records, accidents and incidents, compliments and complaints, maintenance and safety records and medicine administration records.

Good ●

# Is the service safe?

## Our findings

People we spoke with told us that they felt safe at Sue Ryder – Thorpe Hall. One person told us that they, “Feel safe and secure,” and that this was because there were, “Doctor’s around every corner.” Relatives spoken to also confirmed that they felt their family member was safe. One relative told us that their family member’s, “Call-bell was in reach.” This confirmed that people could summon help when needed because we saw that there were call bells in place throughout the service. This meant that there were safety measures in place to reduce the risk of harm to people living in the service.

Staff we spoke with showed their knowledge and understanding on how to identify different types of abuse and how to report any suspicions of, or actual harm. They said that they had received safeguarding training and this was confirmed in the records we looked at. Staff were clear about their responsibilities to report any concerns about poor care practice. They told us that they would report concerns to their line manager or nurse. Staff were also aware that they could report concerns directly to external agencies such as the local authority safeguarding team and the Care Quality Commission. This demonstrated to us that staff knew the process in place to identify, report, and reduce the risk of abuse or harm.

Staff were aware of the provider’s whistle-blowing procedure. They knew the lines of management to follow if they had any concerns to raise and were confident to do so. This meant that they understood their roles and responsibilities to the people who used the service.

Care records showed that people had individual risk assessments in place in relation to their identified support, treatment and health care needs. Risks included, falls risk assessments, poor skin integrity, palliative care nutrition screening tool, mouth care assessment, bedrail risk assessment and venous thromboembolism [risk of blood clots]. Risk assessments gave guidance to staff to help assist people appropriately. This guidance helped reduce the risk of people receiving inappropriate or unsafe care and assistance. Records were kept by staff to monitor risk and take action where concerns had been identified.

Staff and volunteers said that pre-employment safety checks were carried out on them prior to them starting work at the service. One volunteer told us how there was a delay in them starting at the hospice whilst they waited for all of their safety checks to come through. These checks were to ensure that staff were of good character. This was confirmed by the records we looked at. This showed that there was a system in place to make sure that staff and volunteers were only employed or volunteered at the service if they were deemed safe and suitable to work with people.

People told us and we observed that although busy, there were enough staff to support people in an unrushed and timely manner. People told us that staff were quick to answer their call-bells, one person told us that their call-bell would be answered, “Within half a minute.” This was confirmed by relatives, one of whom said that their family member’s call-bell was always, “Answered within a couple of minutes.”

Staff explained that there were two consultants covering the service and that they worked from 09:00am to 17:00pm, with an on-call system in place between 17:00pm until 09:00am. The on-call system included hospice doctors and two GP’s, which meant that appropriately skilled people were available throughout the day and night. Staff also confirmed that there were enough staff to be safe and that additional staff would be placed onto the rota when a person was identified as having more complex support needs. Another staff member told us how management prioritised staff well.

One person told us how staff supported them with their medicines. They said that, “Staff tell me what medication I am taking – no surprises.” Relatives confirmed that they had no concerns around their family member’s medication. Records showed that staff only administered medicines after they had received training and that they had been assessed as competent. This was confirmed by the records we looked at. We saw that some people who were unable to take their medication orally were receiving their medication by use of a syringe driver. A syringe driver is a small infusion pump used to gradually administer small amounts of liquid medication. During an observation we saw a nurse setting up a new syringe driver for a person and noted that the person was informed about the medication they were receiving and the reason for the change. We saw that appropriate and accurate records were in place for the syringe driver and other medicines administered by staff. People’s allergies were clearly recorded for staff guidance. We saw that medication and

# Is the service safe?

blood fridges were checked for their temperature daily and there were no gaps within the records. There were suitable protocols in place for the safe and secure storage, administration, disposal and management of medicine.

We found that people had a personal emergency evacuation plan in place in the event of an emergency. There was also an overall business continuity plan which gave details of emergency contacts and their details.

Safety checks for the maintenance of the building, fire equipment and utilities were in place with service records and maintenance records kept. Records we looked at showed that all equipment had annual service checks in place to reduce the risk of equipment failure.

Good ●

# Is the service effective?

## Our findings

Staff told us that they were supported with regular supervisions and that these were a two way process in which they were supported to talk about any topics they wished to discuss. Records we looked at confirmed that staff had '121' meetings and meetings to discuss their performance and review their development with their line managers.

Staff said that when they first joined the team they had an induction period which included training and shadowing a more senior member of the care team. Staff told us that this was continued until management deemed they were competent and confident to provide effective and safe care and support.

We found that staff were knowledgeable about people's individual support, treatment and health care needs. One person told us, "Staff are brilliant from top to bottom…..I can't praise them highly enough." Staff told us about the training they had completed. Training included, but was not limited to, safeguarding adults and children, first aid, moving and handling, food hygiene, infection control, Mental Capacity Act awareness, principles of palliative care, end of life communication skills, falls management, and equality and diversity. This was confirmed by the manager's record of staff training undertaken to date. Staff talked us through the support given by management to develop their skills and knowledge through specialist training and attending conferences and study days. This showed us that staff were supported to provide effective care and support with regular training and personal development.

We spoke with the senior sister about the Mental Capacity Act 2005 (MCA) and changes to guidance in the Deprivation of Liberty Safeguards (DoLS). They confirmed that there were no DoLS applications required for people using the service. We found staff we spoke with were aware that they needed to safeguard the rights of people who were assessed as being unable to make their own decisions and choices. Staff were able to demonstrate knowledge around MCA and DoLS and this was confirmed by the training records we looked at. Records showed and staff confirmed that people's capacity to make day to day decisions was assessed when they first started to use the service. This meant that people did not have their freedom restricted without the legal process being in place.

Our observations showed that staff respected people's choice. One person told us that, "Independence is respected and encouraged [by staff]. [You] are also given choice and choice is respected." Staff explained how they encouraged people to be as independent as they could be with regards to their personal care. One member of staff told us how they respected people's choices, "Consent – you ask permission and await an answer."

Records showed that the hospice staff asked people's agreement to share their information with other health and social care professionals. People were also asked to consent to use their own medications from home and if they would like their family and friends to be informed of their condition. Records showed that documented consent was recorded unless a person was too unwell on admission to sign, where this was also documented. This demonstrated that staff had an understanding of the importance of gaining consent from people.

Each person had a medical file in which doctors and multi-disciplinary teams documented people's required care and planning. An electronic record where nursing assessments and relevant care plans were recorded and a separate risk assessment folder. This record was accessible by external health care professional, community services and GP's. This was to ensure that people received effective and continuity of care and support from all services involved in the person's well-being. On discharge from the hospice people were referred on to the community Macmillan nurse, district nurses and as appropriate linked with hospital palliative nurses. One person we spoke with said that the staff were working hard with other agencies to ensure that everything they needed support wise, would be in place before they could be discharged back home.

People were supported to maintain their well-being at the hospice by the involvement of visiting health care professionals. The hospice had agreements in place with the local NHS community services to offer on-going support to people with occupational therapy and physiotherapy input. These health care professionals also formed part of the multi-disciplinary team meetings held weekly to review and update people's health, care support and treatment needs as part of a clinical team. A visiting professional confirmed to us that the information staff provided was clear and concise. They said that doctors

Good ●

# Is the service effective?

were available to talk to if needed and that there was a good working relationship between the services. This meant that all services worked together to provide effective support to people with serious or life limiting illnesses.

Staff demonstrated a good knowledge of people's conditions and the treatments available to them. Relatives and a person using the service told us how communication with staff was good and that staff spent time to help people and their relatives understand their conditions and what support would be available to them. One person told us that, "Family are given information about [my] care and can speak to staff….support is there if and when needed." A relative told us that, "They are managing [family member's] care and pain, [staff] are very informative around pain relief and are approachable. Staff go out of their way."

Care records we looked at were written in a personalised way about the individual. On admission people were put on a 48 hours personalised care assessment. This was completed by nursing staff and covered people's assessed needs for pain relief, breathing, nausea, elimination, skin integrity, personal care needs, communication and spiritual needs. This was confirmed by staff we spoke with. Individual care plans were then created around people's health, care, support and treatment needs. Records showed that people's care records were reviewed on a regular basis. These reviews were carried out to ensure that people's current health, support, treatment and care needs were effective and documented.

One person we spoke with told us that, "[The] food here is very, very good." They also told us how fruit and vegetables were always available and that there were, "Healthy meal options." The person also confirmed that you could go, "Off menu," and be offered alternative choices. Menus we looked at showed that people were offered a range of healthy food options. Food served on the day looked appetising and people were encouraged by staff and volunteers to eat and drink. People and their relatives were able to bring in their own snacks and drinks in to the hospice with them. One relative told us how they used the relative's fridge when visiting and that staff offered food and drink choices to their family member. We spoke with two kitchen staff who told us about the individual requirements of people's diets, including people's likes and dislikes and how they would support a person with any specific dietary requirement. Our observation showed that throughout the day people were offered refreshments by staff and volunteers. This showed us that people were supported with their nutritional and hydration needs.

Good ●

# Is the service caring?

## Our findings

We saw that staff supported people in a patient and compassionate manner. People and relatives we spoke with spoke very highly of the care and treatment they or their family member received. One person said that the service was, "Exceptional. Everything is done with a means to the end to look after the patient." Another person told us that staff were, "Very efficient, they are very, very, good." One relative told us that Sue Ryder –Thorpe Hall was an, "Amazing place, [the] level of care is a lot, lot better. Staff are friendly [and] so calm." Our observations showed that there were friendly and positive relationships between staff and people using the service. Staff and volunteers were seen treating people and their relatives with kindness and compassion. One person told us how they had found staff remained patient and showed empathy towards the people they cared for.

People and their relatives told us that staff respected their privacy and dignity. One person told us that, "All of the time privacy and dignity is respected. In the bath, [certain] areas are covered to ensure [my] dignity." Observations showed that people were dressed appropriately for the temperature of the service and in a manner which maintained their dignity. We saw that staff pulled the curtain around people's bed when supporting them so that people's privacy was maintained.

Care records were written in a personalised way that collected social and personal information about the person, and included their likes and dislikes and individual needs. This was so that staff had a greater understanding of the person they were supporting. The care records we looked at showed that staff reviewed and updated support and care plans as needed. This helped ensure that people were provided with care and support by staff based upon their most up-to-date care and treatment needs.

We saw that people's family and friends were able to visit the service without any restrictions. There was a play area within one of the communal lounges to help make children feel more comfortable at the service when visiting a family member. We were also told that pets were welcome at any time. We asked the senior sister what facilities were available for relatives wishing to stay with their family member overnight. They told us that there was no separate room in which relatives could stay in but there were recliner chairs by people's beds which could be slept in by a relative if they wanted to stay overnight.

People were actively involved in decisions around their end of life care. Staff told us that people's individual end of life wishes were documented as guidance for staff and gave us examples of how they had adhered to these wishes. One staff member told how, "In the last chapter of their life [it is] an honour and a privilege that people allow you to care for them."

On admission, where appropriate and if the person wanted to discuss this at that time, doctors completed an advanced care plan. Records showed that where people had an understanding of their condition they had made choices about their end of life wishes including their preferred place of death or whether they wished to be resuscitated, this was documented appropriately. Where a person did not want to have this discussion this was respected by staff and recorded within the care record. This meant that people's end of life wishes were clearly documented for staff.

A Chaplain and bereavement team worked at the hospice to help support people and their families with their holistic well-being. One person confirmed that they could have, "Holistic chats with the priest about faith or non-faith." We saw that communal rooms within the hospice could be used to house private meetings with families or as quiet rooms when needed. Staff said that they felt well supported by the bereavement team who could also be accessed at any time for a debrief after a person had died. They said that the Chaplain was available for families during this time, but staff could also seek their support if needed.

Advocacy information was available for people if they needed to be supported to make decisions. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Good ●

# Is the service responsive?

## Our findings

We saw people being supported by staff and volunteers to pursue their individual interests, whether that was reading a magazine, newspaper or using a personal computer. One person we spoke with told us that they were given a choice to take part in activities but chose not to do so. A relative told us that their family member was not bored at the service as they enjoyed chatting to other people and staff. People were also supported with complementary therapies such as massage or reflexology to help with their well-being. We saw that people were supported to visit the services coffee shop or sit in the communal gardens. For people who visited the day service, activities included baking, arts and crafts or trips in to the community to take part in sailing or attend a tea dance.

Care records showed people had input to aid with their well-being from the chaplain, the family counsellor, visiting complementary therapists and the patient affairs officer. The hospice did not have an assigned social worker to support people using the service. However, the role of the patient affairs officer was to help provide advice and support to people in response to their queries and concerns around benefits and continuing care assessments. This meant that the hospice had put in place a support service for people who used the service.

Prior to using the service, people's health, care, support and treatment needs were assessed, planned and evaluated during each visit to the service. This was to ensure people had an individualised plan of care and support in place when they came to us the service. Care and support plans were documented to show that people had been involved in the process of agreeing their plan of care and the review of these plans. Care records showed that people's care and support needs, and personalised risk assessments were known, documented, and monitored by staff. This assured us that staff would be working with the most up to date information about a person they were supporting.

We saw that care records, where appropriate, included a personalised care plan for the last days of life. On the day of inspection no patients were on this care plan. This care plan was a set of documents to support staff to provide good quality end of life care for people who were expected to die in the next few hours or days. The care plan was discussed with the person and/or their family, alongside doctors and nurses. It included sections on anticipatory prescribing for the most common symptoms at the end of life, management of nutrition and hydration, spiritual and psychological support. The final section of the care plan gave guidance to staff what should be done after an expected death in response to people's documented wishes.

Records we looked at showed that the hospice and their staff had received many compliments from relatives and friends of people who had used the service. Where people and/or their relatives had a concern or suggestion to make about the service we saw that records of these were kept. The record documented the concern and any response given, including any action taken as a result of learning from this. People and relatives we spoke with told us that they would raise any concerns or suggestions with staff. One person said, "If you have any concerns [you] can raise them with staff and [you] would be listened to." Staff told us that they knew the process for reporting concerns and that the concerns raised would be responded to by management. We saw evidence of an improvement action put in place by the management after a recent concern from a relative visiting the service had been raised. As a result, the hospice had introduced two hourly checks for each person. These checks included, but were not limited to; pain management, positioning, confusion and anxiety, continence and personal care needs and were documented by staff. This meant that management listened to concerns and complaints raised with them and where possible put actions in place in response to these concerns.

Good ●

# Is the service well-led?

## Our findings

The service had a registered manager in place. The registered manager was supported by a team of clinicians, nurses, care staff, non-care staff and volunteers. Staff spoke positively about the management. One staff member told us that the hospice had, “A brilliant team that are very supportive.” Staff also described the culture within the service as being open and honest. Staff told us that they felt supported by the management. One staff member said that, “Management were very available [to staff]….. [it is] a say what we think culture, very open.” A volunteer went on to tell us that management had an, “Open door, to discuss any concerns,” that they may have. This was confirmed to us by a Sue Ryder award that the staff of the service had won in 2014 for ‘making the future together.’

Staff told us that they were free to make suggestions and raise concerns at staff meetings. They told us that the meeting would start with an overview of the previous meeting minutes and finish with an ‘any other business’ agenda item where staff could raise anything further they wished to discuss. A staff member told us, “I love working here; it’s a very good place to work.” Staff were also asked to complete a survey to provide feedback to the management. Surveys returned showed positive feedback given with a few suggestions to be considered by management. This meant that the service had an ‘open’ and ‘honest’ culture where staff were encouraged to raise a suggestion or concern and feedback on the service.

We saw that some staff had ‘link roles’ within the service. These roles included, but were not limited to; wound care, medicines, spirituality and bereavement, complementary therapies, pain, activities infection control, nutrition. Staff told us that these roles were in place to support staff and be a point of guidance for other staff.

People and their relatives were encouraged to give feedback on the quality of the service provided. A questionnaire was given on people’s discharge from the service asking them for their experience whilst using the service. The responses were then collated by volunteers and fed back to the Sue Ryder quality improvement group. The surveys we reviewed that had been completed by people and their relatives showed high satisfaction with the service provided with only a few suggestions for improvement to be addressed by the service.

Links to the community were established with local school choirs coming into the service to perform for people using the service. Staff also told us that they had on occasion attended a school assembly for older children to discuss Sue Ryder-Thorpe Hall and the service it provides for people. People who attended the day service also took part in activities outside of the service, including on the day of inspection a local tea dance to support dementia awareness week. This meant that the hospice established links within the local community.

There were links with religious organisations to show that the management of the hospice operated an open culture and people were an integral part of the community.

An on-going quality monitoring process was in place to review the quality of the service provided. Any improvements required were recorded with an action identified or action plan to be worked on. Accidents and incidents, care records, mental capacity, palliative care, medicines management, and a falls audit, were some of the areas monitored. This meant that there was a system in place to review and update the effectiveness of a service’s quality improvements. Staff we spoke with told us that a debrief was held with staff after an accident or incident had occurred. These were held to discuss what happened and to ensure that learning came out of the incident to reduce the risk of reoccurrence.

The registered manager notified the CQC of incidents that occurred within the service that they were legally obliged to inform us about. This showed that the registered manager had an understanding of their roles and responsibilities. Staff told us that they received national guidance via their organisation which meant that they had the most up to date guidance and guidelines to work with.