

St Peter and St James Charitable Trust







St Peter and St James Charitable Trust

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?		Requires Improvement	

Overall summary

We inspected St Peter and St James Charitable Trust on 15 December 2014. This was an unannounced inspection. The Trust provides specialist palliative care for people with a life-limiting illness and continuing care for people where longer-term palliative care is necessary. It also offers day care and support for people in their own home.

There was a registered manager in place. 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 and associated Regulations about how the service is run.

Summary of findings

The hospice accommodated 23 patients. On the morning of our inspection there were 14 people, which had increased to 17 by the afternoon. The registered manager described the three categories within the service: the hospice (where end of life was imminent), continuing care (end of life but not imminent) and short term respite care. In addition, the hospice offered support services for 220 people living in the local community. The hospice had also recently developed and implemented a new 'Wellbeing Centre' called Beacon View, which had replaced the existing day care unit.

People were treated with respect and dignity by the staff. They were spoken with and supported in a sensitive, respectful and professional manner and were supported to express their views and wishes about all aspects of their care. Staff had a good understanding of people's individual needs and the support they and their family members required. Each person had comprehensive care and support plans, including risk assessments, tailored to their individual needs. The personalised plans highlighted any additional areas of support required and were developed from a range of physical and psychological assessments, undertaken on referral, prior to admission and during ongoing treatment.

People told us they felt safe and well cared for. One person told us "I feel very comfortable here. I've always been quite shy, but here I feel confident and this is just another part of my life." Another person told us "It's so friendly and welcoming, I can't imagine being anywhere else, it's not like a hospital. I wouldn't want to go home now, I'd rather be here." Relatives said they felt confident and reassured that their loved ones were safe and their medical needs were well met. They were also confident in the staff and spoke positively about the care and support provided. One relative told us "When I go home I know I don't have to worry."

Some concerns were raised regarding the recording systems for medicines and also the process for allocating link nurses and health care assistants.

The visions and values were shared with patients, relatives and staff at the hospice and there was a culture of compassionate care, knowledge and understanding. The management team used a variety of methods to assess and monitor the quality of the service provided. These included regular audits, satisfaction surveys and care reviews. People, relatives and staff spoke positively about the management. They were aware of the complaints procedure and confident that any concerns raised would be taken seriously and acted upon.

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.

People were protected from abuse and avoidable harm. They told us that they felt safe living at the hospice. People had individual assessments of potential risks to their health and welfare and these were reviewed regularly.

There was sufficient staff, with the necessary skills and competencies to meet people's complex care and support needs. Recruitment practices were safe and relevant checks had been completed.

Staffing numbers and skills mix were sufficient to provide a good level of care and keep people safe. People told us there were enough staff on duty and that staff had time to spend with them.

Good



Is the service effective?

The service was effective.

People were supported by staff who had the necessary skills and knowledge to meet their assessed needs.

Staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). There were safeguards in place for people who may be unable to make decisions about their care.

People were supported to have access to healthcare services. Support plans were detailed and incorporated individual health and personal care needs. Plans were reviewed regularly to ensure that people's identified needs were monitored and managed.

Good



Is the service caring?

The service was caring.

Staff involved and treated people with compassion, dignity and kindness.

Communication between staff and people was good. Staff were caring towards people and their relatives and spoke with them in a kind, sensitive and respectful manner.

People were treated as individuals and their privacy and dignity was respected. They received compassionate care, including end of life care that reflected their needs and wishes.

Good



Is the service responsive?

The service was responsive.

Good



Summary of findings

The views of people using the service, their relatives and other visitors were welcomed and informed changes and improvements to service provision. People were involved in making decisions about their personal care and welfare.

Individual care and support needs were regularly assessed and monitored, to ensure that any changes were accurately reflected in the care and treatment people received. People's care needs were kept under review and staff responded quickly when people's needs changed.

A complaints procedure was in place and people and relatives told us they knew how to make a complaint if necessary. They were also confident that any concerns would be listened to and acted upon.

Is the service well-led?

Some aspects of the service were not well-led.

Some concerns were identified regarding the overseeing and management of certain systems within the hospice, including the recording of medicine administration.

There was clear management structure and an open and positive culture within the hospice. People and their relatives were regularly consulted, they felt informed and involved. They told us the manager was "approachable" and "supportive."

Accidents and incidents were appropriately recorded and analysed. There were robust quality assurance systems in place to help maintain and improve service provision.

Requires Improvement



St Peter and St James Charitable Trust

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 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was carried out on 15 December 2014 and was unannounced. The inspection team consisted of two inspectors and an expert by experience, with experience of supporting people with complex needs and end of life care. 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 inspection we checked the information that we held about the service and the service provider. The

provider completed a Provider Information Return (PIR). 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.

During the inspection, we spoke with eight people who used the service, six relatives, six Health Care Assistants (HCAs), three staff nurses (RGNs), the Clinical Services Manager (registered manager) and the Patient and Family Support Services Manager. We also spoke with the Wellbeing Centre Manager, the Operations Director, the Chief Executive and a clinical consultant.

We also spent time observing care practices and looking at documentation, which included five people's care records, staff training records. We also looked at records relating to the management of the hospice, including quality assurance records, and arrangements for processing complaints.

The last inspection of this service was on 6 November 2013, no concerns were identified.

Is the service safe?

Our findings

People who used the service told us they felt safe within the hospice. One person told us “Oh gosh yes absolutely, safe and secure here. I think it’s because I feel that I’m in safe hands.” Another person told us “There’s always someone around, you never feel left, they’re checking on you regularly even if you haven’t called them.” People consistently spoke of prompt responses to their call bells and, in each bedroom, we observed that everyone had a call bell within easy reach. One person told us “It doesn’t matter whether it’s day or night there’s always someone around that comes to you.” Another person told us “I even have a neck pendant [a portable type of call bell] as well that I can use in case I’m not in my room.”

Relatives spoke positively about the service, they had no concerns about the way their family members were treated and felt that they were safe. One relative told us “We have no concerns at all and have the peace of mind knowing she’s safe and in the best place.” Several relatives made similar comments, including “When I go home I know I don’t have to worry.”

The provider had developed comprehensive safeguarding policies and procedures, including whistleblowing. We saw documentation was in place for identifying and dealing with allegations of abuse. Staff had received training in safeguarding people and demonstrated a good understanding of what constituted abuse and their responsibilities in relation to reporting it. They told us they would not hesitate to report any concerns they had about care practice and would ensure people were protected from potential harm or abuse

People told us and we observed there were enough staff to support people’s care and treatment in a timely manner. Staff told us they felt people were safe, the training was good and staffing levels were sufficient to ensure people’s safety. We asked two HCAs about staffing levels. One told us “It feels OK most of the time, but if there are a few off sick it can be a bit tight.” The other HCA told us “What we cannot do we pass on to the next shift.”

People’s risks were appropriately assessed, managed and reviewed. We looked at individual care records, including personal and environmental risk assessments. Where risks were identified, clear management plans had been developed and staff demonstrated awareness and understanding of strategies put in place to keep each person safe. . These included assessments for risk of pressure related skin damage that used a recognised tool (the Waterlow score) and poor nutrition screening using the Malnutrition Universal Screening tool. Assessments and actions that needed to be taken to manage these risks were updated on a regular basis. This helped to ensure people were safe and meant their care and treatment reflected relevant guidance and any risks to their wellbeing were managed safely.

Medicines were administered safely to people. We observed lunchtime medicines being given to people. We saw that, where appropriate, people were assisted to take their medicines sensitively, they were not rushed and simple explanations, appropriate to people’s level of understanding were provided. The nurse was wearing a ‘do not disturb’ tabard and was indeed able to focus safely on their task. People said they had their medicines on time and had pain relief as appropriate. One person told us “They come and check if you need any pain killers so you don’t wait until it gets bad...I’m never left in pain.”

Robust recruitment practices helped to ensure the safety of people and all relevant checks had been completed before new staff started work. Staff files contained evidence that Disclosure and Barring Service (DBS) checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent as far as possible unsuitable people from working with people who use care and support services. We saw application forms had been completed appropriately and in each case a minimum of two references had been received.

Is the service effective?

Our findings

People received care from staff who had the knowledge and relevant skills to carry out their roles and responsibilities effectively. People and their relatives spoke very positively about the service, the staff and the care and treatment they received. People told us the staff were “well trained,” “competent” and that they had “total confidence” in them. One person told us “They know exactly what they’re doing and they know the patients well. I completely trust their abilities....that’s everyone.” Another person told us “I’m very independent in here. I’ve been here two years and I do as I please. I can ask for help if I need it but they don’t take over either so I still do as much as I can for myself.”

People told us that they saw the doctors and other health related professionals as required. One person told us “Only the other day I asked to see the doctor and within 10 minutes I was seen, not like hospital when you don’t know how long you’re going to have to wait and don’t know what’s going on.” Another person told us “Yes the chiropodist comes regularly and does my nails and they’re trying out a new prescription for my glasses at the moment. I think they’re sorting out a new hairdresser as the other one has retired.”

The hospice had a number of counselling staff, both employed and volunteers. There were three part-time employed counsellors and about 20 volunteers, who received induction training and regular support. There was also an effective befriender scheme in place, as part of the Patient and Family Support Services. A chaplaincy service provided a ‘non-judgemental, listening ear’ and an active welfare department advised on any practical or financial problems that people may experience.

Staff told us they were happy with the support and training they had received. Staff received a comprehensive induction programme and essential training was provided both in-house and from external providers. We saw training records that supported this. The hospice also provided external study days at Brighton University. Staff completed competency based assessments, appropriate to their role, to ensure they could demonstrate the required knowledge and skills. Examples of these assessments included;

medication, enteral feeding (feeding through a tube into the stomach) and urinary catheter care. Staff spoke positively about the training, which they said gave them “skills, knowledge and confidence.”

The manager told us that all new staff were supernumerary for the first two weeks and received supervision/appraisal at 13 weeks, six months and at the end of the first year. They told us that although there was currently no formal one to one ‘supervision’ provided for HCAs, other than in their first year, they did operate an “open door policy” and all staff had a mentor. They said group “reflective sessions” were held regularly and clinical supervision was undertaken for clinical nurse specialists (CNS) every six weeks. They also said the appraisal process was being reviewed as there was currently a single system and staff felt that not all of it was relevant to them. Therefore different models were being researched for clinical and non-clinical staff.

Each person in the hospice had a named nurse and HCA. There were also linked specialist nurses (champions) for infection control and specific conditions, for example, motor neuron disease. The Hospice also participated in various external support networks, including the motor neuron disease forum.

Comprehensive policies were in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA and DoLS provide legal safeguards for people who may be unable to make decisions about their care. The registered manager confirmed that one application for authorisation had been submitted in respect of a person living with dementia and Parkinson’s disease. We spoke with staff to check their understanding of MCA and DoLS. They demonstrated a good awareness of the code of practice and the need to work in people’s best interests. They confirmed they had received training in these areas and training records supported this. Clear procedures were in place to enable staff to assess people’s mental capacity, should there be concerns about their ability to make specific decisions for themselves, or to support those who lacked capacity to manage risk.

As well as considering people’s capacity to make decisions, staff also ensured that, wherever practicable individuals were asked for their consent to care and treatment. This was evident from care plans we saw and also through our discussions with people and their relatives. People told us

Is the service effective?

they remembered giving consent for treatment and said they had been involved in their care planning. One person told us “Yes I signed something about all that. My daughter would know about all that - but it’s all fine.” Another person said “Yes, we all sat down together and went through everything.” A relative, who felt very reassured, told us “They keep you fully informed every step of the way, you always know what’s happening and why and it’s in a language you understand. They always check as well to make sure you have understood everything.”

People’s nutritional needs were assessed and recorded and records were accurately maintained to ensure people were protected from potential risks associated with eating and drinking. We saw that people were consulted about their food preferences each day and were given options. Food that needed to be pureed was separated out into each food type and not all mixed together. During lunchtime we observed staff sensitively and discreetly supporting people

who required assistance in an unrushed and calm manner. We saw staff sitting with people, giving good eye contact and talking with them whilst gently encouraging them to eat.

Everyone we spoke with was very complimentary about the food and said that there was enough choice for them. One person told us “The food’s lovely and appetising and if I’m hungry or want a snack anytime I only have to ask.” Another person told us “I’ve not that much of an appetite at the moment but they’re really trying to tempt me, nothing’s too much trouble.” Relatives were equally positive about the meals and the kindness of the staff. One relative told us “The food is really nice here...I could eat it myself - much better than hospital food.” Another relative told us “Dad had a sore throat the other day and they came and asked what he might fancy. They got him some sorbet...that’s what it’s like here; they’ll always go the extra mile.”

Is the service caring?

Our findings

People and relatives spoke of a great depth of caring and compassion. One person told us “You couldn’t find a better place. I’m very well looked after. The nurses are lovely - very sympathetic and caring.” Another person told us “I have a feeling of relief here and I can’t be cared for any better.”

Another person told us I wouldn’t want to go home now, I’d rather be here.” Relatives spoke of how welcome they were made to feel. One relative told us “They are amazing, just brilliant, so kind, caring and helpful.” Another relative told us “It’s excellent, I’m very happy with Dad’s care.”

Staff were knowledgeable and showed a good understanding of the individual choices, wishes and care and support needs of people. They were respectful of people’s needs and demonstrated a sensitive and compassionate approach to their role. Communication between staff and people was sensitive and respectful. We saw people being supported with consideration and gently encouraged by staff to express their views. We observed that staff involved people as far as possible in making decisions about their care, treatment and support.

People said they felt they were treated with respect and dignity. One person told us “Yes they always knock and speak to me well. The doors and curtains are always closed if they’re doing anything personal with you.” Another person said “There’s always somewhere private to chat if you need it.” We saw ‘Care being given’ notices on people’s doors, when they were being attended to. This prevented interruptions and ensured the individual’s privacy and dignity was maintained. We also observed many examples of staff speaking sensitively and respectfully with people and treating them with dignity and kindness. The thoughtful consideration showed by staff was demonstrated by a relative who told us about her father. They said “He was always very smart and it’s so important to him that every day he is clean, nicely dressed, clean shaven and smells of his aftershave, as though he’s at home – and the staff make sure that he is.”

We saw in individual care documents that there was sufficient information for staff to provide people with consistent, personalised care and treatment. One plan

contained detailed guidance on how to support the individual in managing pain during different times of the day. Staff demonstrated to us how they updated plans and records on a continual basis, ensuring that care and treatment was planned, delivered and recorded appropriately.

Care plans were comprehensive, structured and well maintained. Typically plans contained an initial assessment with sections on independence, skin integrity, nutrition, mobility, elimination and pain. Where necessary there were daily fluid balance charts with a record of intake and output. There were also charts recording blood pressure, temperature, pulse and respiration. This helped ensure staff had a good understanding of people’s needs and provided care and treatment in a structured and consistent manner.

We were informed that care plans for continuing care patients were reviewed each month, or more frequently if there were changes taking place. For hospice patients receiving end of life care the reviews were daily and, in the last few days it was on an hourly basis. End of life care plans included a copy of the patient charter for the care of the dying, and consisted of a clinical initial assessment, an individualised end of life care plan, medical review forms, care plan evaluation forms and staff guidelines for treating specific conditions. In one plan, there was a record of multidisciplinary meetings and discussions. These included the options for palliative care and the decision making leading to the continuation of radiotherapy. There were also notes explaining the person’s preferences for arrangements leading up to and after death, including funeral arrangements. This meant that people received care, including end of life care that was personalised and reflected their needs and wishes.

The hospice also provided practical and emotional support for relatives and the bereaved. In addition to the many welfare services available through the ‘Patient and Family Support Service’ there was a chapel, where remembrance services were held throughout the year. A member of staff told us that many people found comfort in the chapel and the services gave family, friends and staff the opportunity for “quiet reflection.”

Is the service responsive?

Our findings

People told us they felt listened to and spoke of staff knowing them well, being aware of their preferences and how they liked things to be done. One person told us “I have this chair that can be wheeled anywhere in the building so they’ve taken me to the art group, for yoga, meditation and relaxation. We also do IT and I couldn’t even use a computer before I came here.” Another person told us “I decide what I want to do, depending on how I’m feeling. I go for a walk round every day and call in to see people, especially my friend

Everyone we spoke with felt they could speak up as staff were approachable and would listen. ‘You Said. We Did’ information was displayed throughout the hospice, a range of patient/relative information leaflets were in the reception area as well as a patient/carer information board. During the inspection we received many positive comments and examples of how responsive the service was. One person told us “Every month I like to go shopping with one member of staff, I call him chauffeur ...he’s a volunteer and he takes me into town in my wheelchair to get my comics.” Another person told us “I like to go to the Chapel on Friday, so they take me. The staff here are marvellous and take care of everything I need.”

Throughout the assessment and care planning process, staff supported and encouraged people to express their views and wishes, to enable them to make informed choices and decisions about their care and support. People told us they had opportunities to be involved in the development and review of care plans if they wished. We observed staff regularly asking about people’s comfort and welfare and responding promptly if assistance was required. People told us they could express their views and were involved in making decisions about all aspects of their care and treatment. People said they felt involved. One person told us “Yes my care plan was done with me and my family together and we talked about me.”

We saw an example of how people were involved in their care planning. On the wall in one person’s room, there were diagrams and guidance describing their rolling techniques and foot positioning in bed. We spoke with the person, who had been involved in developing the guidance and knew exactly what they were all about and why they were there.

We observed that people’s rooms were personalised with family photographs, memorabilia and possessions reflecting their individual personalities and interests. One person had their heroes and personal art work displayed on their walls. Relatives told us they felt that communication with staff at the hospice was “excellent” and they were kept informed and up to date regarding care planning and any changes in family member’s condition or health care needs.

The effective communication and inclusive culture at St Peter and St James was also described by the registered manager and chief executive who told us they all work hard to maintain “positive links with patients and their families.” The hospice produced a very friendly and informative quarterly newsletter called ‘Caring’. They also provided a range of family support services, including a welfare and chaplaincy service.

A Patients’ Forum meeting was held quarterly. One person told us “This is when you can bring up anything you like about what you want to tell them about what you want.” The objective of the forum was: ‘to enable patients, residents and family members/carers to raise and discuss general issues of importance to maintain and improve the quality of care. The hospice will also consult with the forum, where appropriate, regarding future plans for service delivery.’

Minutes of recent Patient Forum meetings demonstrated the open and inclusive culture within the hospice and included discussion on equipment such as hoists, beds and the proposed purchase of high back chairs. Other topics discussed included the production of a hospice calendar, to be sold to raise funds and the opening of the new café and a survey of what patients, carers and staff would like to see provided.

A major consultation was carried out in 2013 and considered the temporary closure of the day hospice and the development of the new Beacon View Wellbeing Centre. The Chief Executive told us about the consultation groups that were set up with patients regarding colour schemes, the types of activities that would be provided and “what else might be important to centre users.” As part of our inspection process, we had contact with people who had used the previous facility on a ‘day patient’ basis. They expressed satisfaction with the arrangements for their care at the day hospital. They were critical of the consultation process and unhappy with the “unnecessary” changes,

Is the service responsive?

which had resulted in their attendance at the centre being reduced by one day a week. However they continued to attend the Wellbeing Centre and take a central role in the patients' forum, although not always confident that their voices were being heard.

The provider maintained a register of complaints. This detailed each complaint, recorded the findings of any investigation and noted any actions that were taken to change practice or improve the service. We looked at how complaints had been managed and investigated, in accordance with the provider's published procedures and whether they were resolved to the satisfaction of the

complainant. A complaints procedure was displayed and was made available to people, their relatives and other visitors to the service. The registered manager told us the staff team worked very closely with people and their families and any comments or concerns were taken seriously and acted upon immediately. People and their relatives told us they were very satisfied with the service and hadn't had cause to raise a complaint. However, they told us they were aware of how to make a complaint and felt confident that any issues they might raise would be listened to and acted upon.

Is the service well-led?

Our findings

There was a clear management structure in place. Staff were aware of the roles of the management team and told us the managers were approachable and had a visible presence within the hospice. They told us they were confident in the management of the service and said the managers were committed to providing a good quality service for people who they cared for and supported. They also confirmed they were happy and confident in their own individual roles.

People told us the management of the hospice was “well run” and “organised.” One person told us “There’s no trouble here whatsoever, it runs like clockwork.” Another person told us “It’s well run and well taken care of. Everyone knows what they’re doing and it’s always very calm.”

However concerns were identified regarding some medicine administration record charts and the corresponding medicine incident reports. There were a number of incidents reported since the hospice had introduced a new medication document from September 2014. The incidents concerned medicines that were not given to the patient when they should have been. We also found some discrepancies in the paper and electronic recordings of these incidents. The manager had recognised that soon after the introduction of new recording forms, the number of incidents had increased. They had a discussion as a team and realised the problem was that nurses were not turning all the pages of a person’s medicines record to see the full list of medicine to be given.

As soon as the issue was identified the number of incidents began to fall and none were reported in December. The RGN said that they had now returned to a protocol, to reduce possible distractions, where the nurses giving out medication always wore a red tabard saying that they should not be disturbed. A nurse said that the problem with maintaining both paper based and electronic records, was that not everyone updated both systems. They acknowledged that with two systems there was the potential for risk due to duplication and inaccuracies. This was discussed during the feedback session, where we were given assurances by the registered manager that the recording issues would be addressed.

Some concerns were also raised regarding the overseeing and management of certain systems within the hospice. We were told that each person in the hospice had a named nurse and HCA. Some people, although satisfied with their care, were unaware of their named nurse or HCA. A consultant we spoke with considered that a person’s continuity of care might be improved by reviewing this arrangement. They also suggested introducing a named doctor and/or senior nurse for each unit, which would provide an overview and help to ensure consistency.

The Chief Executive told us they had reviewed their values, vision and mission statement in consultation with the staff team. The vision for the hospice stated ‘We want to make a positive difference to the experience of everybody in our community who faces death or bereavement by offering choice and support through our expert care, knowledge and understanding.’ The Chief Executive explained how this vision underpinned their values of ‘nurturing, professional, unified, transparent and empowering’. They also described how through information, literature and presentations, these values were shared and understood by patients, relatives and staff at the hospice. We were shown a copy of the presentation and also spoke with people, relatives and staff who confirmed being aware of these values. One member of staff told us “It’s what we do here.”

The provider had systems and procedures in place to monitor and assess the quality of their service. These included regular audits that included staffing levels and medication. They also regularly sought the views and experiences of people they supported through satisfaction surveys and care reviews with people and their relatives. We saw very positive comments from relatives, which expressed a high level of satisfaction with the care and support provided. These included: ‘Thank you for all your kindness, care and support and for just being there for all friends and family. You are all wonderful people and we thank you so much.’ Another relative wrote ‘Thank you for the care you provided my husband and the support given to me and our family over this difficult time.’

Effective systems were in place to monitor incidents and accidents at the service and implement learning from them. Incidents were recorded accurately and people’s care records were updated to ensure that up to date information was available to staff.

There were quality assurance and clinical governance systems in place to regularly review and improve the

Is the service well-led?

service. These included health and safety audits, medication as well as checks on care records and infection control. Audits were evaluated and where required, action plans were in place to drive improvements. The service had identified that improvements could be made to the quality of information recorded in the care plans and we saw that appropriate plans were in place to ensure action was taken, within identified timescales.

CQC registration requirements were adhered to and the provider's legal obligations regarding the submitting of notifications were being met.