St Joseph's Hospice Association

St Joseph's Hospice

Inspection report

Ince Road
Thornton
Liverpool
Merseyside
L23 4UE

Tel: 01519243812
Website: www.jospice.org.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

St Joseph's Hospice provides care and support to terminally ill people and their families within the Liverpool and Sefton areas. The hospice has accommodation and facilities for 29 people. It provides care for people with progressive, degenerative conditions and for people with brain injury and terminal illness. The hospice also provides end of life care and support to families of terminally ill patients. There were 25 people accommodated at the time of the inspection.

This was an announced inspection which took place over three days on 4, 5 & 7 July 2017.

The service had a 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 of the Health and Social Care Act 2008 and associated regulations about how the service is run.

The service last received a full comprehensive inspection in July 2016 and at that time we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations; we rated the service as 'requires improvement'. A Warning Notice was served in relation to Regulation 12, of the Health and Social Care Act 2008, Regulated Activities Regulations 2014, by way of unsafe medicine management.

We completed a 'focused' follow up inspection in October 2016 and we found breaches relating to care and treatment, medicines, safeguarding and acting on complaints had been met; the service remained in breach of regulations regarding good governance because they failed to ensure the proper arrangements were in place to assess, monitor and improve the quality and safety of services and maintain accurate complete records of the treatment provided to people. The hospice retained an overall rating of 'requires improvement'.

We returned in July 2017 to carry out this comprehensive inspection and found the service had not improved and there were further breaches of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. The service had been unable to demonstrate sustained compliance with standards of quality and safety and there was a failure to sustain improvement, by way of safe medicine management at the hospice. In turn, we found a failure of governance and oversight by the registered persons. We found breaches of regulations with respect to; Regulation 12 Safe care and treatment (medicines management), Regulation 11 Consent to care and treatment, Regulation 17 Good governance and Regulation 18 Staffing (with respect to support and competency of staff).

We found medicines were not administered safely. We found failings with safe and secure storage of medicines, lack of safe administration including missed dosages of medicines and lack of consultation and safe protocols when people refused medicines, lack of guidelines for specialist administration of medicines and lack of adequate records for the administration of prescribed thickeners (used for thickening fluids for people with swallowing difficulties). We found there was a failure to assess the risks to people's health and

wellbeing.

We found that when people were unable to consent, the principles of the Mental Capacity Act 2005 were not always followed.

We found the nursing staff was not receiving periodic supervision and staff employed were not appraised to ensure acceptable levels of competence were maintained or they demonstrated the necessary competences and skill to carry out specialised care safely.

Some of the systems for auditing the quality and safety of the service were not being carried out consistently and had not identified the failings we found. Overall governance did not provide adequate monitoring of standards in the hospice and we found repeated breaches of regulations. There was a failure to maintain accurate and complete records of care and treatment for people. We also found that care documents were not always stored securely which compromised their confidentiality.

Following the inspection we found the seriousness of the breaches of regulations posed a 'high' risk to people receiving care at the hospice. We used our enforcement procedures and served an urgent notice telling the provider to take action to put things right. The notice also told the provider not to admit any more people to the hospice until the areas of risk we identified had been addressed. The statutory notice we issued remains in place at this inspection.

We found examples where people's privacy and dignity was not always upheld.

You can see what action we took with the provider at the back of the full version of the report.

Care plans were completed and were being reviewed so people's care could be monitored. We found care plans 'generic' and lacking in personal preference and identity of people's individuality. We made a recommendation regarding this.

Prior to our inspection we received information of concern regarding staffing levels at the hospice. At the time of our inspection we found staffing levels were appropriate to meet the care needs of the people staff supported.

People receiving care at the hospice told us the meals were good and well presented. People were offered a good choice of hot and cold meals and plenty of drinks throughout the day.

We observed positive interactions between staff and people receiving care at the hospice. Feedback from people and relatives was very positive in respect of the staff.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We saw checks had been made so that staff employed were 'fit' to work with vulnerable people.

Staff receive safeguarding training and policies and procedures around abuse and whistleblowing were available. Contact details for reporting an alleged incident to the local authority were displayed for staff to refer to.

A complaints procedure was in place and people, including relatives, we spoke with aware of how to complaint and felt comfortable in raising any concerns with the staff.

On the inspection we visited all of the units in the hospice and found them to be clean. Staff were seen to adhere to basic infection control practice when attending to people and serving meals. We saw there were hand wash facilities available in all bathrooms and toilets including liquid soap and paper towels for staff use.

The registered manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the hospice.

Special measures:

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not administered safely. We found concerns around the way some medicines were administered and recorded which placed people at high risk of harm.

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

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported.

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

There were processes and checks in place to monitor the environment to ensure it was safe and well maintained including risk of infection.

Is the service effective?

Inadequate

The service was not effective.

Staff were not supported through appraisal, supervision and the hospice's training programme.

When people were unable to consent, the principles of the Mental Capacity Act 2005 were not always followed in that an assessment of the person's mental capacity was not made.

We found the hospice did not always support people to provide effective outcomes for their health and wellbeing such as assessment and monitoring of pain.

There was a failure to maintain accurate and complete records of care and treatment for people.

We saw people's dietary needs were mostly managed with reference to individual preferences and choice. We found some food supplements were not monitored in accordance with

instructions.

Is the service caring?

Requires Improvement

The service was not always caring.

People reported positive experiences at the hospice but we found some examples of care where people's privacy and dignity were not being respected.

We found care records were not always held securely which compromised their confidentiality.

We found there were good systems in place for supporting bereaved relatives.

People told us they felt involved in their care and could have some input into the running of the hospice.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

Care plans were completed and were being reviewed so people's care could be monitored. We found care plans 'generic' and lacking in personal preference and identity of people's individuality. We made a recommendation regarding this.

There was access to some therapeutic activity at the service.

A process for managing complaints was in place and people we spoke with and relatives knew how to complain. No complaints had been recorded in the last 12 months.

Is the service well-led?

Inadequate

The service was not well led.

Some of the systems for auditing the quality of the service needed further development and did not provide adequate monitoring of standards in the hospice.

There have been repeated failings with the service with the provider not able to meet statutory requirements.

There was a registered manager in post who provided a lead for the hospice.

We found the management structure was well defined with clear

lines of accountability and responsibility.

There were some systems in place to get feedback from people so that the service could be developed with respect to their needs and wishes.

St Joseph's Hospice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 was an announced inspection which took place over three days. The inspection team consisted of an adult social care inspector, a pharmacist / medicines inspector and a 'specialist advisor' with a back ground in end of life and palliative care.

Before the inspection, 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. Prior to the inspection we reviewed information we had received about the provider since the last inspection. We made contact with the local authority quality assurance team and also the local clinical commissioning group (CCG) to ascertain their views about the quality of the service provided.

During the visit we were able to meet and speak with four of the people who were staying at the hospice. We spoke with nine visitors included family members. As part of the inspection we also spoke with, and received feedback from a health care professional who was visiting the hospice to provide a person with on-going support.

We spoke with the registered manager, in patient manager, chief executive officer (CEO), site and services manager, four nurses, six care/support staff, the cook, a member of the domestic staff, complimentary therapist, volunteer co-ordinator and family support worker.

We looked at the care records for four of the people receiving care at the hospice in order to track their care and treatment. We also looked at medication records, four staff recruitment files and other records relevant to the quality monitoring of the service. These included safety audits and quality audits including feedback from people staying at the hospice and visitors/relatives. We undertook general observations and looked round the hospice, including people's bedrooms, bathrooms and the lounges, dining rooms and external grounds.

Inadequate

Is the service safe?

Our findings

The hospice was previously inspected in July 2016 and we found that medicines were not managed safely. Staff had not received medicines training and there were problems with supply and storage. Medicines were not given as prescribed and stock checks showed that medicines were not always given when they had been signed for. We found problems with nurses making thickened solutions incorrectly. In October 2016, a further inspection took place and some improvements were seen.

During this inspection, we looked at how medicines were managed for seven of the 25 people and found concerns about some aspects of medicines handling for each of those. We checked storage and stocks of medicines in all three units. We spoke with five staff responsible for giving medicines and examined documentation and training records.

Medicines were provided from a local pharmacy, and a local hospital provided Controlled Drugs (CDs), (medicines that require extra checks and special storage arrangements because of their potential for misuse). A member of staff from the hospital completed CD audits every three months. A system had been introduced to ensure medicines could be obtained out of normal working hours using other pharmacies in the area. The hospice employed non-medical prescribers who were nursing staff who could write a prescription when needed.

Staff told us they had received recent medicines administration training and we saw evidence of 23 registered nurse medicine competency records. Twenty-six care staff had also attended medication training provided by the hospice.

We found one medicine that was not stored securely, on unit one we found a person's enteral feed being used to hold a fire door open. All other medicines were stored in locked cupboards and temperature sensitive medicines were stored in locked fridges. There was evidence of daily temperature monitoring however, on unit one, the fridge was not within specified range of 2-8oC. The fridge had been recorded as out of range (1.2 oC-11.9 oC) for five consecutive days. Action recorded stated 'awaiting technician' but when inspectors asked staff whether medicines in the fridge had been isolated, it was unknown.

We looked at people's medication administration records (MARs) and examined seven from the 25 people's records in detail. People did not have a photograph in their MAR record or wear any kind of identifying wristband, which made it more difficult to identify individuals when giving medicines.

People did not always receive their medicines as prescribed. We saw discrepancies with six medicine stock balances against the MAR chart records and internal audits demonstrated there had been 60 error/discrepancies since 1 Jan 17. We found some people had missed doses of antibiotics, anti-epileptics and anticoagulants. We found incorrect instructions on one person's antibiotic medicine. Paracetamol had been administered to one person and had not been recorded on their chart. One person had not had their barrier cream applied as directed by the doctor, which meant they were at risk of developing pressure sores. One person had regularly refused their medicine and no assessment had been made to ensure that this

person had capacity to make an appropriate decision.

There were no instructions for 'when required' medicines to help staff know when and how to give medicines that were not always needed. One person had six laxatives prescribed as 'when required' and there was no guidance which one should be given.

Medicine can be disguised in food or drink when it is in a person's best interest to continue to receive medicine. We saw no guidance to assist staff to administer medicines in this way so there was a risk this might not be done safely.

We looked at the records for five people that were given their medicines straight into their stomach via an endoscopic gastrostomy (PEG/RIG) tube. Guidance how to administer medicines was not available for staff to follow. Some medicines are available in liquid form and other needed to be dissolved or crushed in order to be given. The records for these people were not always accurate and we found that water flushes, needed before and after medicines to stop blockages, were not always recorded. An accurate fluid intake could therefore not be calculated which meant people may be at risk of under or over hydration. Records of when the tube site was rotated was also not accurately recorded which if not done regularly could lead to infection.

A number of people were prescribed a powder to thicken their drinks because they had difficulty swallowing. One record we examined had no record of when a thickener had been used or to what consistency. The correct consistency is important to minimise the risk of choking.

Over a period of three inspections from July 2016 we have found serious failings with medicine management that have exposed people using the services to risk of significant harm.

These findings were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people whether they felt they received a safe service at the hospice. People and relatives told us they did. A relative said, "Yes, very safe, it always has been." When talking about staffing, the relative went on to say there was always staff assistance when it was needed.

Prior to the inspection we received information of concern around staffing levels. We therefore looked at how the units were staffed and this included speaking with the staff on duty, people receiving care and support and relatives. The majority of staff we spoke with felt recent changes implemented by the management team meant there were not enough staff on duty. Staff believed that the numbers had been reduced to such a level that they did not have adequate time to care for people and two said that they thought care was being compromised. Others stated that although they believed they were short staffed that they were still giving exemplary care. We had a mixed response when we talking to relatives about staffing levels. One relative expressed no concerns about the standard of care and believed that there were adequate staff members on duty, whilst another relative said their family member did not get the same level of care now.

We looked at the staffing numbers on all three units and at the time of the inspection we found these were satisfactory. For example, on one unit there were two nurses and three care staff on duty for 11 people. Staff support was observed to be given in a timely manner with calls for assistance answered promptly. An 'escalation' tool had been implemented to help assess staffing numbers based on people's dependencies and other factors affecting the service provision. This was used by staff to highlight changing dependencies

in people's care needs. The registered manager informed us this tool was effective; however, there was also recognition of professional judgement which needed to be taken into account when assessing the number of staff needed for each unit. We discussed the use of the tool and other clinical descriptors which could be included when assessing staffing requirements, along with further clarification for staff regarding its use. We looked at escalation forms for one unit and out of 24, only two indicated that the level of staffing made one unit unsafe; these were annotated that the safety was compromised during the 13:00 medicine round and the other at 17:30 when a staff member stayed after shift to assist with care. The registered manager provided examples of actions taken when a risk was identified and this included moving staff on to different units to support people safely.

For a person who was receiving one to one support it was difficult to extricate information from the rotas whether the member of staff providing one to one care was included in the general staffing numbers. This care was provided in two hour shifts therefore making it even more difficult to establish this information. We discussed better evidencing of this support on the staffing rotas, which the registered manager confirmed they would action. During the inspection we observed the person receiving one to one support in accordance with the staffing numbers at this time. Overall we found numbers of staff appropriate to deliver care.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed where obvious hazards were identified. Any repairs that were discovered were reported for maintenance and the area needing repair made as safe as possible. We also saw safety checks on equipment such as specialist mattresses, to ensure they were set at the correct pressure, and moving and handling equipment.

We looked at fire safety. A 'fire risk assessment' had been carried out and updated at intervals. Fire safety checks were carried out of the premises and equipment. Staff received fire safety training and undertook fire safety checks of rooms. During the inspection we saw a corridor being used to store items and also a number of doors wedged open. We discussed our findings with the registered manager and also a fire safety inspecting officer who had recently conducted a visit to the service. The fire safety inspecting officer informed us they were satisfied with the management of fire safety at the hospice following a visit to the service in May 2017 and also a subsequent visit by them following our inspection in July 2017, when we brought our findings to their attention. They informed us that management were looking to provide external storage space for items and also to provide automatic release devices for all fire doors, for example door guards, as not all of the fire doors were fitted with this form of device. They informed us the staff were well trained in fire safety. We spot checked safety certificates for services including electrical safety, gas safety, fire safety and Legionella compliance. These were in date.

Staff had access to personal protective equipment (PPE), such as aprons and gloves and we saw they used this when providing care. This meant that appropriate action was taken to ensure the hospice was clean and the risk of infections or contamination limited. Hand gel in one area was not available in all rooms, but was positioned at central points. One member of staff informed us that the individual hand gels used to be available for staff to wear but this was no longer available.

We saw a cupboard used for storing chemicals was unlocked. We brought this to the registered manager's attention and appropriate actions were taken to ensure the safe storage of these items.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported to senior managers. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report through

any concerns they had. We saw that the local contact numbers for the local authority safeguarding team were available.

We checked, on this inspection, how staff were recruited and the processes followed to ensure staff were suitable to work with vulnerable people. We looked at four staff files and asked the registered manager for copies of appropriate applications, references and necessary checks that had been carried out. We saw these checks had been made so that staff employed were 'fit' to work with vulnerable people.

We looked at how clinical care was managed so that people were supported to minimise risk. We found key areas of clinical care were being monitored. For example, one person who had a pressure ulcer had been assessed appropriately and had a clear plan with specified use of specialist equipment and treatment for the ulcer. Pressure ulcers are caused by 'sustained pressure being placed on a particular part of the body'. We found this area of care continued to be managed appropriately.

For people who were at risk of falls, we saw this risk was appropriately assessed measures in place to increase staff observation and use of equipment to help keep people safe. This included the use of bed rails. Dietary needs and nutritional requirements had also been recorded and assessed routinely. We found not all units had implemented a formal nutritional assessment tool such as the Malnutrition Universal Screening Tool – MUST. The registered manager informed us this was being implemented across all the units.

Inadequate

Is the service effective?

Our findings

We looked at staff training and support. We found a lack of clinical supervision for nursing staff and none of the staff had received an appraisal to help ensure acceptable levels of competence were maintained or to provide some assurance they demonstrated the necessary competences and skill to carry out care effectively.

For example, there was no competency assessment of staffs' ability to manage and care for a person with a PEG tube in situ and their medicine. Therefore, the registered provider had no assurance that staff were equipped with the skills and competence to provide safe effective care and treatment. We found there were concerns with the way care was managed for a person with a PEG tube. We found little evidence of updates / training for registered nurses in other key clinical areas such as management for syringe drivers used to manage people's pain at the end of life (for example). There were sufficient numbers of syringe drivers on the unit and these were regularly maintained and serviced, however there was no annual update for staff on use of this equipment and no evidence of a framework to check on-going competency. New members of staff were shown how to use the equipment but no competency checklist was used.

The PIR stated, 'The Registered Manager and the new In Patient Unit Manager regard appraisals and supervision as being vital in developing staff and reviewing their practice, competencies and future aspirations'.

We found, however, staff had not received appraisals. The registered manager was unable to provide any documents since their employment to support any previous staff appraisals. Prior to the inspection the registered manager had acknowledged the need for staff appraisal as this had not been undertaken by previous management. The registered manager told us they were in the process off arranging appraisal training for staff and appraisal programme to commence. We could find no evidence of clinical supervision sessions for registered nurses having taken place. Following the inspection the registered manager assured us that dates now being arranged. Care staff were receiving supervision on an ad hoc basis and we saw some dates when these had been held.

The importance of specific training, supervision and appraisal for staff is to help ensure staff are supported in their role, and their competency to carry out safe and effective care is monitored and maintained.

These findings were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had identified the previous mandatory training at the hospice was poor and they informed us and this had been replaced in April 2017 by an e-learning system, sourced through a 'hospice-specific provider'. We saw a record of training (training matrix) which showed where staff were up to date with 'statutory' or required training. With the recent introduction of the new e learning programme this was 'was work' in progress.

Training in medication had been given to nursing staff following the last comprehensive inspection and competencies around general medication administration had been completed for nursing staff in August 2016. Three nurses had attended a palliative course and the registered manager was in process of arranging further training for end of life care and bereavement.

Staff meetings were held and a regular 'walk around' of the units by the management team were undertaken where staff were given opportunities to discuss any matters arising. We visited all three units at St Josephs and staff morale appeared to be low with mixed response to the changes being made by management team. These were mainly around the changes to staffing levels, staff being asked to work on all three units rather than being based on one unit (thus reducing use of agency) and the removal of the unit manager post.

Staff we spoke with said they did not always feel supported and new changes had not yet been fully embedded and staff said they had 'less time' for training; for example staff indicated they were required to complete e-learning programmes but did not have enough time to do this.

We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) [MCA]. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We found there was a failure to provide care and treatment for people with the consent of the relevant person. An example of this was for a person who had complex and serious health care needs and was on a variety of medications including antibiotic therapy over a prolonged period of time. There was an indication on the person discharge letter for hospital that medications were given 'covertly', without the person being aware; medicines were to be crushed and mixed with juice. When we reviewed the person's care file and records we could find no evidence of assessments being made of the person's capacity to consent to care and treatment. The person was 'refusing' to take medicines but there had been no assessment by staff with a view to understanding if they had sufficient mental capacity to make an unwise but informed decision in relation to the refusal of the medications. It was unclear from the records whether the hospice had informed the doctor of the person refusing their medicines. There was also no record that medicines had been administered as advised by the hospital discharge letter.

The failure to consider if the person had sufficient capacity and if they did not, consider the need for a best interest decision as to the use and administration of covert medication had placed the person at risk, as they had not been receiving medication which had been prescribed for serious medical conditions.

We could find no reference to the use of covert medications in the policies and procedures at the hospice. Following the inspection we were advised that; 'The Covert Administration of Medication Policy has been completed in draft form and sent to members of the Clinical Governance Sub Committee for comment. We expect this policy to be fully operational by Friday 28th July 2017'.

These findings were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we reviewed the care of five people living at the hospice. When we looked at people's care notes we saw references to referrals and support for people from a range of health care professionals. A

health care professional told us staff sought advice from them at the appropriate time.

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

We found care needs had been assessed and care plans where available to guide staff in carrying out peoples care needs. For example, physical health, mobility, sleep, spirituality, nausea, anxiety. We saw these were all 'generic' with people's names added to them. One care plan for pain lacked detail around efficacy of pain control and type of pain, staff had good knowledge however and this was updated during the inspection.

Charts for monitoring pain were available but provided limited information. These were completed if a person had pain at the time of administering analgesia with a 30 minute review prompted. However, if pain had not resolved after 30 minutes there was no indication of further intervention or monitoring. Pain assessment appeared to be made by verbal scale of 0-5. No alternative pain scale was available for people with dementia, learning difficulties or other communication issues. Following the inspection we were advised the hospice had reviewed our feedback and were awaiting receipt of suitable charts from a nominated hospice dementia link nurse, who had been tasked with sourcing appropriate documents.

We inspected the fluid balance charts for five patients and found that the records were incomplete. Where a care plan was seen, the guidance was not being followed. Total daily intake was not always recorded and one patient with a history of acute kidney injury had received between 575ml and 950ml daily for the six days prior to the inspection when their daily target was 2000ml. Not having the appropriate levels of fluid intake increases the risk of a person becoming dehydrated, and increases the risk of further kidney injury.

Monitoring of people on food supplements was a concern for two people we reviewed who were being given less that prescribed. One person was receiving half the amount the dietician had recommended following a request from a family member. Staff had agreed to the request and we found no record of consultation with professionals regarding the change. The second person had conflicting information on the printed care record and the medicines administration record. The person was receiving half the food supplements written on the care plan. We asked staff to clarify and was told the change was following verbal instruction from a dietician. Staff could not find any written evidence in the care records.

There was a failure to assess the risks to people's health and wellbeing.

These findings were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the people within the hospice at the time of inspection appeared to have meals served in their own rooms, although a dining room was available on all units. No menu was available in people's rooms. People indicated that they were satisfied with the meals provided and stated that they had a choice. If they wished to eat something not on the menu staff were able to provide this. Relatives had open access to the dining room and were able to make themselves a drink at any time.
People we spoke with said they generally enjoyed the food and felt there was choice available.

People who were on special diets had their needs met. We saw assessments of people's nutritional needs were made using an approached assessment tool.

Requires Improvement

Is the service caring?

Our findings

All of the people and relatives interviewed stated that staff were caring and kind. Several indicated that the hospice was a very quiet caring environment and that they had nothing but praise for the care that was given. One person commented, "Staff are very good, I feel very well looked after." Another person said, "The staff seem very caring." A person on one unit told us, "Staff have time to sit with me. My eyesight is too poor to see the paper so they read to me." The hospice had also received very positive comments from relatives on the 'I Want Great Care Website'. This enables members of the public to provide feedback about the service provision.

'Thank you' cards from many people and relatives were seen on the wards and in the offices. These appeared to indicate that the care had been second to none, and many bereaved relatives noted that they were cared for as well as the people.

People's privacy and dignity appeared to be maintained with interventions being carried out behind closed doors. Do not disturb indicators were used on doors.

We did, however, make some observations of concern.

We reported some concerns around confidentiality of people's care records. These were kept within a cupboard within the office. The door to the office had a key pad to ensure security when left unattended. However the notes were taken to the dining room by staff for annotation. This room is also used by relatives and confidential notes could be overlooked by relatives within this room. One relative we spoke with had clear information about the care needs of another person within the unit and told us that they had obtained this information from staff. There was a failure to maintain securely accurate and complete records of care and treatment for people.

These findings were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Standards of dignity and respect were at times compromised by the terms used within the service's documentation and the spoken word. We saw for example, the word bedbound, referring to people being nursed in bed, and the word 'difficult' used to describe a person who needed extra support; these were recorded in the escalation tool used to review people's dependencies. A number of people needed support with their meals, however the term 'needs feeding' was recorded on a meal preference sheet and in conversation, three staff referred to people by their room numbers, rather than their preferred form of address. We saw an observation chart was being completed without the person's name or date of birth on the chart. Similarly, medicines stored in the medicine trolley, in one area, were kept in containers with room numbers rather than their names.

People indicated that if they required care or support call bells were answered quickly. However, we observed four people in one unit who were able to use a call bell did not have call bell within reach. One

person was heard to be shouting for help for five minutes before a member of staff attended. A sign on door indicated 'do not disturb' but no intervention was taking place. The door was pulled to, but not closed, after staff had previously attended. The person repeatedly called for a nurse during our observation; the person's call bell was out of reach.

We highlighted an issue regarding an out of date oral liquid medicine on unit one. Staff responded by suggesting the person could have a subcutaneous injection instead of sourcing a new supply of liquid. This did not consider the person receiving the medicine and having an unnecessary injection.

A visitor was concerned and reported that deceased people were kept within the ward environment until an undertaker could collect the person. Because of the location of their friend's room, they were able to clearly see the undertakers arrive at the hospice. They found this quite distressing and on two occasions had angled the blinds in such a way as to prevent their friend seeing this. They thought staff members should have been more mindful of this and ensured the person in this room could not witness these events.

These findings were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The hospice had regular systems for supporting bereaved relatives. Cards were sent out by the family support worker approximately four weeks after bereavement. We were shown leaflets about the service and the family support worker told us how they met with newly admitted patients and their families the day after admission to provide support.

Relatives appeared to be welcomed to visit at any time, although there were no specific facilities for overnight, relatives were able to stay overnight if they so wished. We saw a number of people accessing the grounds with relatives and enjoying the sunshine.

The PIR for the service said, 'We believe that by looking after patients and family equally, our objective is achieved. Thereby looking after the whole family's welfare in a caring and holistic way'.

A befriending service was in operation within the hospice and volunteers spent time with people who felt lonely or wished to have interaction with other people beside family members. Staff informed us these befrienders were 'matched' to people to ensure they had shared a common interest. Details of the local advocacy service were available should people require this support.

At the time of the inspection there were no people on 'end of life care'. An 'End of Life Care' (EOLC) plan is used within the hospice. Completed copies of EOLC plans were examined and appeared to be well completed. Staff were aware of how to obtain advice with regard to any escalating symptoms when medical staff were not in site. We discussed the arrangements for anticipatory medication [medication ordered in anticipation of people's care needs at the end of life] and found satisfactory systems in place.

Requires Improvement

Is the service responsive?

Our findings

We reviewed four people's care files and found them to be completed with respect to care and support for areas of people's care including mobility, health, skin integrity and nutrition.

Care records held an assessment of people's needs; this ensured the service was aware of people's needs and that they could be met effectively from admission. There were also specific assessments of areas such as, nutrition, health and mobility. People had a plan of care. A care plan provides direction on the type of care an individual may need following their needs assessment.

The PIR we received before our inspection stated: 'Individual personalised care plans are formulated on admission and as needs identified which are reviewed periodically. Documentation in regards to patient care is reviewed at regular periods throughout the day'.

We found, however, care plans where written from a 'generic' base or descriptive formula and lacked any personalisation with respect to people's individual care needs, for example in respect of their preferred routines. Another example was advanced care plan documents seen in the care files expressing decisions around end of life care and treatment; these also appeared generic, lacking personal detail and not individualised. One care plan had an incorrect name written in one section which was then amended. In another plan there was inconsistent use of a name and derivative which made it difficult to tell what the person's preferred name was. There was no evidence seen of individualised care planning pertinent to people's specific sexuality or diversity. There was no evidence to indicate that people had a choice in their daily routine.

The importance of such documentation is that it reflects basic approach and values around treating people as individuals.

We recommend the provider completes a review of care plans to ensure that they provide sufficient detail and level of personalisation to assist staff to deliver more individualised care.

The majority of care plans reviewed were in line with review dates. Staff we spoke with had knowledge of people's care needs and were able to tell us about these.

One unit appeared to be housed within a particularly Christian environment with indicators of Christian faith clearly visible. We were informed by staff that any religious symbols in the rooms would be removed upon request. The hospice has a chapel and this was used by some people. Eucharistic ministers attended the hospice to administer communion to people who wished to receive it. Some staff were aware of where to access information about rites and rituals of different religions. However there was no evidence of religious texts for people of other faiths.

The provider information advised us that the registered manager and staff were aware of the need to develop activity and therapeutic input for people and this was expressed; 'We can improve by expanding the

family support service and identifying new areas of help and advice. I would like the hospice to look at helping families and patient's in developing memory boxes, taking hand prints and possibly looking at whether we can take a lock of hair, enhance staff training and recruit more volunteers as patient befrienders and volunteers on the wards. To recruit more volunteer therapists to give the hands on touch support to patients/families and staff if required as well as hairdresser and manicurist'.

People had access to the complaints procedure and this was available to people within the hospice. People we spoke with told us they knew how to raise concerns and relatives agreed. The PIR stated there had been no complaints about the service in the last 12 months. One relative told us they had raised a complaint a while ago and they had been listened to by staff on the ward but were not sure if they have taken it any further.

We looked at processes in place to gather feedback from people and listen to their views. The registered manager told us about an on line survey called 'I want great care' were people and their relatives could leave feedback about the service. We also saw compliments recorded on thank you letters. We noted that most comments were positive about the care received at the St Josephs. Some of these comments were included in the PIR such as; "A huge thank you to all the staff who provide such a high level of care and for making his last couple of months comfortable. We would also like to thank you for your compassion to us his family", "Thank you all for taking such good care of my friend. With heartfelt thank s to all of you for your care and attention shown", "Thank you for all your support and kindness shown to our family" and "My heartfelt thanks to all of you for making my mum's last few weeks so comfortable."

Inadequate

Is the service well-led?

Our findings

On this inspection we found systems and processes were in place to help ensure quality assurance monitoring of the service but concerns remained around the effectiveness based on our findings. We found on-going failure to have sustained systems and processes that ensured effective assessing, monitoring and improvement in the quality and safety of services provided.

In July and October 2016, the Commission found the registered provider to be in breach of governance [management] arrangements by way of a lack of safe medicine management. We found, eight months later at this inspection, there continued to be failings in relation to safe medicine management. Since January 2017, the hospice found, and has reported to the Commission 60 medicine errors.

The medicines management policy dated 11 May 2017 stated that audits should be performed at least monthly and discrepancies recorded on a medicine discrepancy form. We saw examples of medicine discrepancy forms completed by staff, however, staff could not tell us about actions taken or route cause analysis to analyse and help improve safe standards.

We found the discrepancies reported by staff on one unit in May 2017 were not included in the registered manager's medication drug error monitoring audit, which indicated the audit process was not robust. We also found additional medicine errors at this inspection that had not been reported appropriately. An audit conducted by the medicines optimisation team from South Sefton Clinical Commissioning Group (CCG) on 29 June 2017 found a number of medicine concerns.

We also found breaches of regulations regarding the gaining of people's consent to care and treatment with respect to provisions under the Mental Capacity Act 2005. We found staff were not being supported by formal systems of supervision and appraisal so that the provider could be sure of staff competency in key areas of care. Aspects of people's privacy and dignity were also compromised and had not been identified or addressed by any of the on-going auditing processes.

We conclude there has been a failure by the registered persons to satisfy compliance as to good governance at St Joseph's Hospice. Systems and processes have continued not to operate effectively, in terms of assessing and monitoring the quality and safety of services provided and assessing, monitoring, and mitigating risk to the health, safety and welfare of people receiving care.

We had been provided with previous provider action reports and updates from the Chief Executive officer (CEO) and registered manager following the comprehensive inspection in July 2016 and the focused inspection of October 2016, but we again found failure to meet regulatory requirements and additional breaches.

These findings were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The governance structure for St Joseph's Hospice was clearly defined. Seven members form the Board of Trustees and they attend quarterly meetings and an annual general meeting. There were four sub committees – finance, overseas, clinical governance and retail. Report from each subcommittee present their findings in each meeting of the Board of Trustees.

The CEO reported the changes that had been made to the governance arrangements at the hospice including the introduction of an entirely new clinical management team between September 2016 and May 2017 to improve the clinical governance and monitoring processes. Changes included, the introduction of a new hospice-specific e-learning system to deliver mandatory training to staff, a clinical risk register to log and track specific clinical risks, a new communications frameworks to facilitate learning & reflection, new clinical tools such as the 'escalation tool' and audit tools such as the daily medicines management audit, an electronic records system for complaints & concerns and a revised internal HR systems and processes to ensure fair, consistent and equitable treatment of staff.

There was acknowledgement by Trustees that change had been needed to the culture of the organisation and some ways of working, though staff had found difficulty in accepting these; staff interviews conducted supported this. We found morale of some staff was low as they felt the changes had not been introduced effectively.

Staff felt the culture of the hospice had changed over the last few months and they appeared very dissatisfied with management. Several staff indicated that changes and new documentation were imposed with no consultation. One relative appeared to have information about recent redundancies and changes to staff rotas, and inadvertently said they had been informed by staff. Staff indicated they thought the staffing levels were inadequate. They indicated that they were required to complete e-learning programmes but did not have the time to do this. Three of the staff we spoke with staff said they had no issues with the changes.

Staff meetings were held at ward level, management and with Trustees. Evidence of significant events, safeguarding referrals, concerns/complaints and drug errors were discussed. The CEO and manager said they were aware of some of the issues we identified and provided assurance as to measures being taken immediately; for example staff training and support, medication management and changes to staffing the units. Following the inspection we received further action plans and copies of audits undertaken to supplement already existing action plans.

We were informed about a new in patient manager to support the registered manager and work alongside the nursing staff to implement new care documents. Service policies were to be reviewed. We found the registered manager did not have any formal supervision but did attend peer group meetings through hospice managers' meetings.

The Care Quality Commission [CQC] had been notified of events and incidents that occurred in the service in accordance with our statutory notifications. This helped CQC to monitor information and risks regarding St Joseph's Hospice.

From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection for the hospice was displayed for people to see.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People reported positive experiences at the hospice but we found some examples of care where people's privacy and dignity were not being respected.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent When people were unable to consent, the principles of the Mental Capacity Act 2005 were not always followed in that an assessment of the person's mental capacity was not made.

The enforcement action we took:

We served an urgent Notice of Decision imposing conditions on the Provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not administered safely. We found concerns around the way some medicines were administered and recorded which placed people at high risk of harm. There was a failure to assess the risks to people's health and wellbeing.

The enforcement action we took:

We served an urgent Notice of Decision imposing conditions on the Provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Some of the systems for auditing the quality of the service needed further development and did not provide adequate monitoring of standards in the hospice. There was a failure to maintain accurate and complete records of care and treatment for people. There have been repeated failings by the service with the provider not able to meet statutory requirements.

The enforcement action we took:

We served an urgent Notice of Decision imposing conditions on the Provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not supported through appraisal, supervision and the hospice's training programme.

The enforcement action we took:

We served an urgent Notice of Decision imposing conditions on the Provider's registration.