

St Leonard's Hospice York

St Leonard's Hospice

Inspection Report

185 Tadcaster Road

York

North Yorkshire

YO24 1GL

Tel: 01904 708553

Website: www.stleonardshospice.org.uk

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Summary of findings

Overall summary

St. Leonard's Hospice is a hospice service that is located on the outskirts of York. The hospice has twenty in-patient beds and incorporates a Hospice@Home service. In addition to this, a maximum of fourteen people per day have access to day care; this part of the service is not required to register with the Care Quality Commission. However, as some people who access day care have also used the in-patient or Hospice@Home service, we spoke to them as part of this inspection. On the day of this inspection some bedrooms were being refurbished so there were only ten people using the in-patient unit.

There was a registered manager in post as the time of this inspection and they had been registered as the manager for two years. A registered manager is a person who is registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

People told us that they felt safe whilst using the hospice. Staff and volunteers had been recruited following robust policies and procedures that ensured only people

suitable to work with vulnerable people had been employed and there were sufficient numbers of staff. Staff had undertaken training on safeguarding adults from abuse and they displayed a good knowledge of the action they would take to manage any incidents or allegations of abuse. Staff had undertaken other training that provided them with the skills to carry out their role effectively.

People's individual circumstances and lifestyle had been taken into account when their care or treatment plan had been devised. People who were important to the person had been consulted and their needs were incorporated into treatment plans. There were appropriate risk assessments in place that ensured people's safety, allowed people to take responsibility for their actions and be as independent as possible, but remain safe.

There were some quality assurance systems in place that monitored people's satisfaction with the service and that audited the systems in place. However, there was no overall clinical governance system in place and medication audits had not identified the issues that we raised.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Medicines were administered safely but were not disposed of in a timely fashion. You can see what action we told the provider to take at the back of the full version of the report.

There were appropriate risk assessments in place to promote people's safety and people who used all of the services provided by the hospice told us that they felt safe whilst they were being supported or treated by staff. Staff had been recruited following robust policies and procedures.

People's best interests were managed appropriately under the Mental Capacity Act (2005) and none of the people who used the hospice had Deprivation of Liberty Safeguards (DoLS) in place. Deprivation of Liberty Safeguards are used to determine whether any restrictions placed on a person amount to a deprivation of their liberty and must be authorised.

Are services effective?

People told us that they felt in control of their care and treatment. They said that they were consulted about their care, including their wishes for end of life care. People told us that their pain was being effectively managed and one family member told us, "My relative is in very little pain."

We saw that bedrooms contained the equipment needed to promote a person's independence. They were spacious enough to allow staff to assist people with specialised equipment such as wheelchairs and hoists.

Some people had used day care or the Hospice@Home service prior to being admitted to the in-patient unit and this helped to promote a smooth transition and reduce people's fears. Staff had information about advocacy services that they could share with people who wished to seek independent advice.

Are services caring?

Staff made sure that people and their relatives were involved in developing their care and treatment plan. Care plans included information about the person's previous lifestyle, the people who were close to them and their hobbies and interests. This information was used by staff to provide individualised care that met the person's specific needs and wishes.

Summary of findings

People told us that they felt that staff really cared about them and that staff were attentive and listened to them. One person said, “Staff attend to you straight away when you call for them.”

Relatives also told us that they were supported by staff. This applied to staff working for the in-patient unit and the Hospice@Home service. One relative told us, “They (the staff) make you think that anything is possible.”

A health care professional told us that hospice staff were very skilled and that their input had a positive effect on the grieving process for families.

Are services responsive to people’s needs?

People told us that they were supported to make choices and decisions about their care. These were reviewed regularly and people knew that they could change their mind.

People were asked about their hobbies and interests and then supported to follow these by staff. One person told us that their spiritual and emotional needs had also been considered.

Relatives told us that they could visit people at any time and that they could stay overnight if they wished. Bedrooms could be adapted to enable this to happen.

A health care professional told us that the Hospice@Home service was invaluable, especially when providing support at short notice. They said that the Hospice@Home service could respond to a request for a service ‘out of hours’, whereas some other support services could not. They also said that, when someone required more support than a district nurse could offer, the Hospice@Home service played a significant role.

Are services well-led?

There were some quality monitoring systems in place, including a system to investigate complaints. However, the audits carried out by the hospice had not identified the concerns about medication that we found. The clinical governance systems needed to be more robust and transparent.

The registered manager said that the Hospice@Home service supported between one and ten people at any one time in their own home. She said that there was an ‘on-call’ clinician available to support both the in-patient unit and Hospice@Home service so that staff were always able to obtain advice and support.

The numbers of staff employed ensured that people received the care and support they required. There were systems in place to share information with staff but these needed to be expanded.

Summary of findings

We saw that there was a complaints system in place and people told us that they would be quite happy to discuss any concerns they had with staff. Staff told us that they would make sure that people were aware of the complaints procedure.

Summary of findings

What people who use the service and those that matter to them say

All of the people who used the service told us that staff were excellent, and that they felt all of the staff and volunteers who worked at the hospice cared about them and listened to them. One person said, “Staff are wonderful – nothing is too much to ask. They wait on you hand and foot.” Health care professionals from other organisations confirmed this and told us that the hospice had “Excellent staff who provided an excellent service.”

People also told us that they felt safe whilst using the service and relatives said they were confident that people were safe whilst being care for by hospice staff. One relative told us, “I have been able to pop in and out all day and the health care assistant told me that everything would be fine.”

One person said, “Staff are very caring – they often know what is wrong before I do.” Relatives also said that they felt their needs were considered and they felt supported. One person said, “It was always made clear that the service was for dad and to support us.” Another person said, “They have far superior skills compared to other teams that we have been involved with.”

On the day of the inspection we observed that the hospice had a calm and positive atmosphere and the people who we spoke with confirmed this. One person told us, “It is a lot more peaceful and tranquil here than the hospital.”

St Leonard'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 was planned to check whether the provider is meeting the legal requirements of the Health and Social Care Act 2008. It was also part of the first testing phase of the new inspection process CQC is introducing for adult social care services.

We visited this service on 29 April 2014. The inspection team consisted of a Lead Inspector and a further two inspectors from the Care Quality Commission.

Before this inspection we reviewed all of the information we held about the hospice. We also spoke with a health care professional from the clinical commissioning group who told us that they had no concerns about the service provided by the hospice.

On the day we visited the hospice we spoke with four people who were in-patients, two people who were

attending for day care and two relatives. We also spoke with the chief executive and the registered manager plus other members of staff, including nurses, community based staff and volunteers.

We spent time observing the interaction between people, relatives and staff. We looked at all areas of the hospice, including bedrooms (with people's permission), therapy rooms, the day room, office accommodation and the courtyard and garden areas. We also spent time looking at records, which included people's treatment records, staff records and records relating to the management of the hospice.

Following the day of the inspection we spoke with three relatives of people who used the home care service and four health care professionals who had involvement with people who used the service.

At the last inspection on 4 December 2013 we found that the provider had met the standards that we reviewed.

Are services safe?

Our findings

We identified some concerns about the disposal of medication. The medication policy recorded that controlled drugs (CD's) should be disposed of within one month. However, in a locked cupboard we saw 27 syringes full of a CD that were ready for disposal and these were dated from February 2014. Staff who we spoke with were unclear how often these should be disposed of. A special kit to destruct CD's to render them unusable was readily available to staff, although it was not stored in the medication room.

There was a dedicated medication fridge in the medication room. We saw that medication in the fridge was stored at the correct temperature and that daily temperature checks had been made and recorded. However, there was no record of the parameters within which medication should be stored so there was a risk that staff would not identify when medication was being stored at the incorrect temperature. In the fridge we saw three bottles of antibiotics which were left following a person's discharge home and an insulin pen which someone who had been discharged should have taken home with them. Some medication did not record the date the packaging had been opened.

The medication that had been brought into the hospice when people were admitted was seen to be recorded and stored safely. However, there was a large stock of medication routinely held by the hospice and we noted that the stock and records did not balance. For example, records for gabapentin 300mg and gabapentin 100mg did not balance with the actual medication held in the store cupboard. Staff were not able to say when the capsules had been used, or by which patient, or whether an error had occurred. The stock was checked by a pharmacy technician on a weekly basis. However, they were not based at the hospice and consequently stock balance information was not held at the hospice. This made it difficult for staff to be clear about the amount of medication in stock. Whilst medication audits were taking place, none of the issues mentioned had been identified. This meant there had been a breach of the relevant legal regulation (Regulation 13 of the Health and Social Care Act 2008) and the action we have asked the provider to take can be found at the back of this report.

We saw that treatment records included the details of any medication the person was currently prescribed. We checked some completed medication administration record (MAR) charts and saw that there were no gaps in recording. We checked the CD register and staff explained to us how medication was administered. Two people signed medication records to confirm that medication had been administered and there were clear records of the times and dates of administration. The CD's and the associated records had been checked each morning and evening to ensure that they were correct.

There was a management of medicines policy in place that was reviewed in September 2013. It included information about CD's, recording, storage, self-medication, administering and disposal of medication. The training matrix evidenced that all staff had completed mandatory training, including medicines management, in 2013 or 2014.

People told us that they felt safe whilst staying at the hospice. One person told us that they had stayed at the hospice previously and they said, "I didn't feel frightened of coming back." People told us that staff offered them encouragement and support but never pressurised them into doing what they did not want to do. Relatives told us that they were confident that people were well cared for and safe. One relative said that they felt safe going home for short periods as they trusted the staff to do the right thing and contact them if necessary.

The people whose relatives received support from the Hospice@Home service told us that they felt confident when leaving their relatives in the care of staff. One relative said, "I have been able to pop in and out all day and the health care assistant told me that everything would be fine."

We checked the care records for four patients who were staying or had stayed at the hospice. We saw that an assessment of a patient's abilities in respect of activities of daily living had been carried out and that there were relevant risk assessments in place such as those for the person's skin condition, the risk of bleeding, bed rail safety and venous thromboembolism (VTE) prevention. Care plans had been discussed with the person concerned and signed by the nurse who had helped them to devise the plan. The plans recorded, "Plan discussed and agreed with patient". This was also confirmed by the patients we spoke with.

Are services safe?

Although mandatory training did not include the topic of the Mental Capacity Act 2005 (MCA) for all staff, clinical leads had undertaken training on this topic during 2012. The hospice had a dementia 'lead' who had attended relevant training and had checked care plans produced by the hospice to ensure that they complied with the key principles of the MCA. The hospice also employed social workers who were available to provide expert advice to staff. None of the people who received a service from the hospice had any restrictions placed on them or were subject to continuous supervision and control under Deprivation of Liberty authorisations.

Staff had been recruited following the organisation's employment policies and procedures. Application forms, employment references, evidence of identification and safety checks had been retained in staff records and we saw that people did not start work until all safety checks were in place. A new member of staff who we spoke with confirmed that they had not been able to start work at the

hospice until their employment references and Disclosure and Barring Service (DBS) clearance had been received. This ensured that only people suitable to work with vulnerable people had been employed. We met the Volunteer Services Manager who explained the procedures for recruiting and training volunteers; we found that robust policies and practices were followed.

The topic of safeguarding adults and children from abuse was included in the annual mandatory training programme completed by staff. The staff who we spoke with confirmed that they had received training on the topic of safeguarding adults and children from abuse. They were able to describe different types of abuse and told us what action they would take if they observed an incident of abuse or became aware of an abusive situation. Staff were clear about when they needed to escalate information to a more senior person to take action. There had been no safeguarding incidents at the hospice since the last inspection in December 2013.

Are services effective?

(for example, treatment is effective)

Our findings

People told us that they felt involved in their care provision. One person told us that they felt “Totally in control” of their care and described how they had put their care plan together and how important this was to them. They said that this included regular discussions with the medical staff regarding their medication regime. Relatives also told us that they were involved in people’s care appropriately. A relative told us, “I feel totally involved in X’s care and if I could I would score them (the staff) a million out of a million.”

We saw that people’s care plans included information about their choices for care. One care plan we saw stated, “X likes their fortisip feeds to be allowed to infuse with gravity” and another care plan recorded, “X is now passing urine via sheath. They had previously refused the suggestion of a catheter”.

People had pain management plans in place and there was a multi-disciplinary approach to effective pain management. Observations showed that people utilised syringe drivers and that this was recorded on a 24 hour syringe driver chart; those that we saw had been completed consistently. People were also able to use nerve stimulator machines, physiotherapy and a range of non-pharmacological pain relief to control their pain. Whilst the hospice did not use a specific pain scoring tool, staff were aware of a person’s needs through speaking to them, their past medical history, information shared at the time of their admission, observation and discussion with the person’s family members. The registered manager told us that they liaised with a pain consultant from the NHS Trust to assist them with managing complex pain. People who we spoke with, both at the in-patient unit and people who received care at home, told us that their pain was being managed effectively. One family member said, “My relative is in very little pain.”

The registered manager and nursing staff told us that a new model of syringe driver was due to be introduced over the next three months, following staff training. They said that the new model had security features and would be tamper proof.

We saw that there were advanced care plans in place that recorded a person’s wishes for their end of life care. People told us they had been involved in devising these plans

along with their loved ones, when appropriate. Some people had told staff that they wished to remain in the hospice at the end of their life and other people wished to return home. Discharge planning meetings were held to ensure that these people had safe discharges and, in many instances, support from the Hospice@Home service was part of the discharge plan. For other people, attendance for day care was incorporated into their discharge plan. We saw letters that had been prepared ready to send to the community nursing team at the time of a person’s discharge home to ensure a smooth transition.

People who were an in-patient had sometimes previously used either the Hospice@Home service or attended for day care, or both. They told us that this made them less anxious about their move into the in-patient unit as they were already familiar with some of the staff and/or the premises. One person whose relative had started to receive care from Hospice@Home staff told us, “We had seen the staff before at the hospice so they were not strangers.” A health care professional told us, “Some people are afraid of hospices. Inviting them to day care is a good introduction and is a great support for patients and their family”. We were told that Hospice@Home staff added their comments to district nursing notes and this ensured that everyone involved in a person’s care was aware of their current care and treatment needs.

People who received care from Hospice@Home told us that they had a regular group of staff and that staff were reliable. They said that they always turned up on time and stayed for the agreed length of time.

On the day of the inspection we observed that the hospice had a calm and positive atmosphere. One person told us, “It is a lot more peaceful and tranquil here than the hospital.” A new member of staff told us that they had already identified that staff at the hospice had time to speak to family members and that staff seemed to be “Less stressed” than those who worked elsewhere.

We saw that bedrooms contained the equipment needed to promote a person’s independence. They were spacious enough to allow staff to assist people with specialised equipment such as wheelchairs and hoists. Care records evidenced that a person’s abilities and need for equipment had been assessed. We saw care plan entries such as, “Nursed in bed – is able to use the remote to adjust position” and one person told us, “They have helped me to walk up and down.”

Are services effective?

(for example, treatment is effective)

The registered manager told us that the social work team had information about local advocacy services and they would be able to give people this information if they wanted to seek independent advice.

People told us that staff at the in-patient unit and the Hospice@Home service had the skills and knowledge to carry out their roles effectively. They told us that this applied to both nurses and health care assistants.

Are services caring?

Our findings

On the day of our visit to the hospice we observed that people were treated with the utmost dignity and respect. One person was very poorly and throughout the day a member of staff was at their side holding their hand.

We saw that staff were aware of people's individual needs and that these were recorded in care plans and care needs assessments. Areas covered included difficulty communicating, a dry mouth, reduced mobility, risk of falls, low mood/anxiety, nausea, breathlessness, fatigue and nutrition.

People's care plans recorded information about their previous lifestyle, their hobbies and interests, the people who were close to them and their spiritual needs. There was evidence that people's requests had been listened to. People's particular interests had been noted by staff and action had been taken to make sure that people were involved in activities that were important to them.

People's were supported to have private and intimate time with their loved ones. People's bedrooms had been configured so that there was room for relatives to spend the night with them if they wished to do so and there was access to outside space and attractive views of the surrounding countryside.

Several people mentioned that the hospital had a holistic approach to people's care. The staff team included physiotherapists, occupational therapists, complementary therapists, a chaplain and social workers. Multi-disciplinary meetings were held each week to discuss people's individual needs and how these could be best met.

People told us that staff were very caring and attentive and that they felt that staff listened to them. The comments we received included, "Staff attend to you straight away when you call for them", "Staff are wonderful – nothing is too much to ask. They wait on you hand and foot" and "Staff are very caring – they often know what is wrong before I do."

People's wishes for the end of life care were clearly recorded in care plans. We saw that these decisions could change and, if they did, care plans were updated accordingly so that everyone involved in the person's care was made aware. Multi-disciplinary meetings were held each week so that staff involved in a person's care could discuss their experience of the patient and whether the patient's treatment needed to be adjusted; the patient's views were represented by their nurse. For example, people might be offered support from a physiotherapist as their mobility deteriorated.

A health care professional told us that the Hospice@Home staff were very skilled and "Had done some good work with families." A relative told us, "They (the staff) make you think that anything is possible." They said that the staff looked after them as much as they looked after their relative, and added, "When I leave – if I feel X is not well I inform the staff. Before I reach the car X has sent me a text to say that a staff member has called in to see them." Another relative told us, "She (staff) is already like part of the family. She is an angel in disguise – so pleasant and lovely." Several people described the staff as "Angels."

Another health care professional told us that hospice staff were very skilled and had a positive effect on the grieving process for families. One relative told us, "They have been our rock."

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

People told us that they were asked for their views. For example, people told us they were asked how they wanted to take their medication. We noted that, if it was considered safe for people to administer their own medication and they wished to do so, this could be accommodated.

People said that staff listened to them and responded to their needs. One person said, "Staff are very responsive – they come as soon as the call bell is sounded" and another person told us, "They have far superior skills compared to other teams that we have been involved with." Two health care professionals told us, "The hospice staff are not task orientated and take their time to talk and communicate with people."

A person's ability to make choices and decisions had been recorded as part of their initial assessment. We saw that one person's care plan recorded, "Give X time to respond to any questions, clearly explain to X any planned interventions and give them time to give consent." There was a record to evidence that this had been agreed with the person concerned.

Another person's care plan recorded, "X's preferred place to die is at home" and then a further entry that recorded, "X has changed their mind – wants to stay at St. Leonard's – agreed unless they change their mind again." This evidenced that people were consulted about their care needs, including their end of life care needs, and that discussion continued throughout their stay to give them the opportunity to change their mind. We saw that people had appropriate Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions in place.

People told us about the activities they were interested in and how staff had supported and encouraged them to continue with their hobbies and interests. One person told us that spiritual and emotional support was very important to them. They said that, if they could not get to the chapel, the chaplain would visit them in their room.

We observed and we were told that families could visit people at any time and relatives told us that they could stay overnight if they wished. One person told us how their relatives room was rearranged so that they could stay overnight. People also told us that staff understood that they needed private time together as "Time was very precious to them." One staff member had set up some low level lighting to provide a romantic atmosphere in one person's bedroom.

A health care professional told us that the Hospice@Home service had had a huge impact on community services. They said the district nursing budget had been cut and that this service 'filled that gap'. They said they could not speak highly enough of the service – "An excellent service – excellent staff". They also said, "If you ask any GP or district nurse, they will tell you that they are impressed with the Hospice@Home service."

Another health care professional told us that the Hospice@Home service was invaluable, especially when providing support at short notice. They said, "If someone requests discharge to die at home, district nursing could not respond 'out of hours'. The Hospice@Home service steps in." They also said that, when someone required more support than a district nurse could offer, the Hospice@Home service played a significant role.

Health care professionals told us that hospice staff were "Very good at arranging discharge meetings." They said that staff had good communication skills and ensured that everyone who was involved in the person's care was included in the decision making process, such as GPs, district nurses, hospital staff and Macmillan nurses.

Relatives told us that they were well supported by staff. One person said, "They are there for both of us" and another person said, "It was always made clear that the service was for dad and to support us." People told us that they had been offered additional support from hospice staff including bereavement counselling and advice from a social worker.

Are services well-led?

Our findings

The registered manager told us that the hospice were committed to quality improvement and clinical effectiveness and had jointly funded a post with another hospice for a Director of Clinical Quality and Effectiveness.

St. Leonard's Hospice had a two year strategy in place but no overall quality assurance policy and procedure. There was an executive team with a board of trustees. These were all volunteers from a variety of backgrounds, including nurses, GPs and lawyers. The executive team consisted of a Chief Executive Officer, a Director of Clinical Services, a Director of Finance and Corporate Services, a Medical Director and a Director of Fundraising. The board was divided into five subgroups and these held the executive team to account. The Medical Director chaired the governance sub group and we saw that comprehensive minutes of these meetings were produced. The registered manager told us that relevant information from board meetings was shared via the heads of department meetings that were held following board meetings. The Chief Executive Officer also told us that following board meetings, they held 'board to ward' meetings. However, although there was documented evidence that these meetings had taken place, the staff who we spoke with were not aware of them. This was fed back to the Chief Executive Officer and the registered manager and it was acknowledged that governance needed to be more robust and made more transparent for staff.

We saw that audits were carried out on complaints, care planning systems and medication systems. A hand held electronic device was used to capture key questions about the medication system. These audits were carried out by volunteers with relevant clinical experience. However, we noted that these audits had not recognised the gaps in the system that we had identified.

We saw that the hospice had a complaints procedure that was due to be reviewed in April 2014. People were also given an information leaflet when they started to use the in-patient or day care. We were told that the leaflets were currently being updated in line with the new internet page to reflect the refurbishment of the service. All of the people we spoke with were aware of the complaints procedure and they all said that they would feel comfortable raising concerns with staff. One person told us that they had been told to say if something was not right as the hospice had

"An open door policy." The staff that we spoke with told us that they were aware of the complaints procedure and that they would signpost people to it. There had been no formal complaints made to the hospice during the previous 12 months.

The hospice had recently developed a range of feedback forms as part of a satisfaction survey. We saw that these asked for people's views on food provision, cleanliness, staff attitude, patient comfort and included questions for family and visitors. However, these had not been fully implemented.

A health care professional told us that they had never had a negative report about any of the services provided by St. Leonard's Hospice or the staff that they employed. They said that the feedback they received from people was that staff had the right skills and demeanour and that they "Could not do enough" for people.

The registered manager told us that they did not use a specific formula to determine staffing levels but that they did benchmark themselves against other hospice services, who they met with as a region. However, they had identified minimum staffing levels. For example, if 20 beds were occupied there would be six nurses and four health care assistants on duty on a morning shift and six staff on duty on the afternoon/evening shift. This would include a minimum of three nurses. The overnight shift consisted of four staff, usually two nurses and two health care assistants. The hospice had their own 'bank' of nursing and health care assistant staff to fill any vacancies due to sickness or holidays. The registered manager told us that, when they were newly employed, bank staff initially had to work six shifts over a two month period. This ensured that any staff who worked at the hospice, including the Hospice@Home service, knew the policies, procedures and routines of the organisation.

The registered manager said that the Hospice@Home service supported between one and ten people at any one time in their own home. She said, "We do not provide 15 minute calls or 4 hour blocks; we deliver the care that is needed for however long it takes." She said that some people were supported by a nurse and some were supported by a health care assistant; this would depend on clinical need. The on-call clinician would support both the in-patient unit and Hospice@Home service so that staff were always able to obtain advice and support.

Are services well-led?

Staff had an annual appraisal with a manager or supervisor. We saw that this included a self assessment that they completed prior to the appraisal meeting. These meetings gave staff the opportunity to discuss any concerns with a manager and to discuss any training needs. However, we noted that bank staff did not have an annual appraisal and the registered manager told us that they would look at this. We saw in staff records that new staff had probationary reviews after one month and again after six months and these monitored whether staff were suitable for the post that they had been recruited to. Staff did not have regular supervision meetings between annual appraisals; the registered manager told us that this decision had been made following consultation with staff. The organisation could decide to introduce supervision meetings as part of their clinical governance or staff development policies if they felt these would be beneficial to the running of the hospice.

We saw that staff were kept informed about issues relevant to them at staff meetings and in staff bulletins; staff received individual emails or letters with their pay slip to ensure that they received information such as changes to their working conditions and policies and procedures. However, although they were advised where staff meeting minutes could be accessed, they did not receive their own copy.

We noted that disciplinary action had been taken with staff appropriately to deal with any areas of concern. One staff member's records included evidence of them being required to undertake a medication competency test when a medication error had been identified.

We saw that a palliative care group met four times a year when doctors and other group members discussed current research, best practice guidance including the National Institute of Clinical Excellence (NICE) guidelines, evidence based practice and clinical trials. In-house training had also been developed with consultant clinicians; this helped to ensure that people received the best possible care.

We saw that there were systems in place to investigate and analyse accidents and incidents so that lessons were learned and the same mistakes were less likely to happen again. Staff told us that 'de-brief' meetings were held following any incidents. However, they were not aware of how these linked to the overall governance system.

The hospice had a dedicated maintenance officer. We examined the current maintenance records and saw that all equipment had current certificates in place and was regularly maintained. The hospice was in the process of being refurbished. In the interim period the in-patient bed numbers had been reduced but day care attendance had not been affected. We saw that all areas of the hospice remained safe during the refurbishment work and that the general cleanliness had not been affected.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010: Management of medicines.</p> <p>How the regulation was not being met: The registered person had not protected service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.</p>
Regulated activity	Regulation
Nursing care	<p>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010: Management of medicines.</p> <p>How the regulation was not being met: The registered person had not protected service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.</p>