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	Requires Improvement

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

Summary of findings

Overall summary

An unannounced inspection took place at St Joseph's Hospice on 11 & 12 December 2017.

At the previous inspection of 4, 5 & 7 July 2017 the provider was found to be inadequate and the service was placed in 'special measures' by CQC. We found breaches of regulations in all key questions we inspect (Is the service safe, effective, caring responsive and well led?).

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' are inspected within six months of the publication of the inspection report.

At this inspection we found improvements had been made. This meant the service was no longer rated inadequate and could be removed from 'special measures' by the Care Quality Commission (CQC).

Following the inspection in July 2017 we issued an urgent statutory notice requiring the provider not to admit any further people to St Joseph's Hospice. The urgent statutory notice also required the provider to carry out a review of the quality assurance systems that were in place; the introduction of medicines management audits; the introduction of clinical compliance checks; appraisal of the individual competencies of all persons employed and also the directors at St Joseph's Hospice and to issue a policy that is in accordance with the requirements of the Mental Capacity Act 2005 (MCA) in relation to the use of covert medication and administration of covert medication.

In light of the improvements we found at the December 2017 inspection we have now lifted this statutory notice which prevented people being admitted to the service. The provider had also complied with the other conditions of the urgent statutory notice.

We have revised the rating for the hospice following our inspection; however the service cannot be rated as 'good'. To improve the rating to 'good' would require a longer track record of consistent good practice.

St Joseph's Hospice provides care and support to terminally ill people and their families within the Liverpool and Sefton areas.The hospice provides care for people with progressive, degenerative conditions and for

people with a brain injury. The hospice also provides end of life care and support to families of terminally ill patients. The hospice has accommodation and facilities for 29 people. At the time of our inspection 17 people were receiving a service at the hospice.

People in a hospice receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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.

At the inspection in July 2017 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as 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 issues in the way some medicines were stored.

At this inspection reviewed the management of medicines. The hospice was working closely with external health professionals to improve the medicines arrangements in the hospice. We saw that people now received their medicines safely. Staff who had administered medicines had been trained and had their competencies checked. Storage conditions had improved. This breach of regulation had been met.

At the inspection in July 2017 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the hospice did not always support people to provide effective outcomes for their health and wellbeing, this included monitoring of pain.

At this inspection we saw staff completed care monitoring charts, for example, recording of people's intake and output to help monitor people's health and provide a care evaluation. Care records showed people's plan of care was written in a way that reflected their wishes, preferences, needs and choices. This included reporting on medical conditions and formulating a plan of care for pain management. This breach of regulation had been met.

At the inspection in July 2017 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as some food supplements were not administered in accordance with instructions.

At this inspection we found food supplements were given as prescribed in accordance with people's nutritional assessment. This breach of regulation had been met.

At the inspection in July 2017 we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as staff were not supported through appraisal, supervision and the hospice's training programme.

At this inspection we saw staff received a good level of support and training. Staff had also had an annual appraisal. Staff told us they received good support from the registered manager and that they had access to a variety of training courses. This breach of regulation had been met.

At the inspection in July 2017 we found a breach of Regulation 11 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014, as when people were unable to consent, the principles of the Mental Capacity Act 2005 (MCA) were not always followed, in that an assessment of the person's mental capacity was not made.

At this inspection we saw consent was sought from people around key decisions, including the administration of covert medication. This breach of regulation had been met.

At the inspection in July 2017 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as there was a failure to maintain accurate and complete records of care and treatment for people and people's care notes were taken to the dining room by staff for annotation. This room was used by relatives and confidential notes could be overlooked by relatives within this area.

At this inspection we saw confidential information was securely stored and staff made annotations to people's notes in the office or nurses' station. Staff were aware of how to main confidentiality and told us how this was respected. This breach of regulation had been met.

At the inspection in July 2017 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as 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. We found repeated failings with the service with the provider not able to meet statutory requirements.

At this inspection we found systems and processes for assuring the standards at the hospice were consistent and robust. We saw sight of the effectiveness of the improvements and also how the service was initiating further changes to support the development of the service. Clinical governance was well monitored and discussed at clinical governance meetings. We were assured by the measures taken. This breach of regulation had been met.

People who received in-patient care told us there were sufficient numbers of staff on duty to care for them. Staffing rotas evidenced staffing numbers and skill mix. People told us the staffing levels helped them feel safe and supported.

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

Staff had a good knowledge of safeguarding procedures. The hospice had reported actual or potential harm to the relevant local safeguarding authority and agreed protocols had been followed in terms of investigating. This helped to ensure any lessons could be learnt from and effective action taken. We had also been notified of safeguarded incidents in accordance with our statutory notifications.

A four week menu was in place and we saw people offered choice of well balanced meals. People told us the food was very good. People's nutritional needs were assessed and recorded.

The environment and equipment was well maintained and subject to service contracts and safety checks. All areas seen were clean and kept hygienic.

Staff sought advice from external health and social care professionals at the appropriate time. This ensured people's health was monitored effectively.

People who received in-patient care told us that staff were kind and caring and that they were treated with respect by staff. We saw good level of engagement between people receiving in-patient care and the staff. It was evident that the staff knew people and their relatives well.

Staff were aware of how to maintain people's independence, taking in account current risks and how to manage these effectively.

People receiving in-patient care and their relatives had been involved with formulating the plan of care. We discussed ways of recording this in more detail to evidence their inclusion.

We saw good standards of privacy and dignity for people receiving in-patient care. This we evidenced by our observations, feedback from people receiving in-patient care, relatives and by looking at care records.

Social activities were arranged including holistic treatments such as, aromatherapy.

Complaints received by the hospice were recorded and investigated appropriately.

End of life care was provided at the hospice. Staff had access to training, up to date guidance and support from other hospices in the region to support people to have a comfortable and dignified death.

Feedback on inspection from people receiving in-patient care, relatives and staff was very positive regarding the registered manager's leadership.

The rating from the last inspection was clearly displayed within the hospice as required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was safe.

On this inspection the changes being made would suggest the service was actively addressing the concerns we found at the last inspection. We have revised the rating from 'inadequate' to 'requires improvement' for this key question based on improvements made. To improve the rating to 'good' however would require a longer track record of consistent good practice.

Staff received safeguarding training and followed safeguarding procedures to protect people from abuse.

We found systems in place to manage medicines were safe.

Risks to people's safety were assessed and control measures were in place to help ensure their safety.

Environmental hazards were identified and measures taken to ensure people lived in a safe comfortable environment.

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

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

The hospice was found to be clean with good adherence to the control of infection.

Is the service effective?

Requires Improvement

The service was effective.

On this inspection the changes being made would suggest the service was actively addressing the concerns we found at the last inspection. We have revised the rating from 'inadequate' to 'requires improvement' for this key question based on improvements made. To improve the rating to 'good' however would require a longer track record of consistent good practice.

Staff followed the principles of the Mental Capacity Act (2005).

People were supported to access health and social work professionals as needed.

People's nutritional needs were assessed and monitored by the staff.

Staff told us they were supported through induction, regular ongoing training, supervision and appraisal.

Is the service caring?

Good

The service was caring.

Staff were kind, caring and treated people with respect and dignity.

Care files showed that people were encouraged to be as independent as possible and people we spoke with agreed.

People and their relatives were involved with the development and review of their plan of care.

For people without the support of family, information on advocacy services was available.

Is the service responsive?

Good

The service was responsive.

Each person had an individualised plan of care. The plan of care contained details around people's preferences, choices and wishes for their care and treatment.

Complaints were recorded and investigated appropriately.

People had access to social activities including complimentary therapies.

Staff received training and had access to relevant policies and documentation to support people at the end of life.

Is the service well-led?

Requires Improvement

The service was well led.

On this inspection the changes being made would suggest the service was actively addressing the concerns we found at the last inspection. We have revised the rating from 'inadequate' to 'requires improvement' for this key question based on

improvements made. To improve the rating to 'good' however would require a longer term track record of consistent good practice.

Systems and process were more robust and were effective in monitoring the service and driving forward improvements.

Staff sought feedback from people and relatives to gain their views about the hospice.

There was a registered manager in post and feedback regarding the leadership and management of the service was very positive.

The rating from the last inspection was clearly displayed in the hospice for people to see.

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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection which took place on 11 & 12 December 2017. The inspection team consisted of an adult social care inspector, two medicines inspectors and a 'specialist advisor' with a back ground in end of life and palliative care.

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, local clinical commissioning groups (CCG) and safeguarding team to discuss the findings from their recent visits and to ascertain their views about the quality of the service provided.

During our visit we were able to meet four of the people who were staying at the hospice. We spoke with three visitors included people's relatives.

We spoke with the registered manager, in-patient manager, site manager, cook, three nurses, four care/health care assistants, two members of the domestic team and a 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 eight 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 around the hospice, including people's bedrooms, bathrooms and the lounges, dining rooms and external grounds.

Requires Improvement

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 the supply and storage of medication. Medicines were not given as prescribed and stock checks showed that medicines were not always given when they had been signed for as being administered. We found problems with nurses making thickened solutions incorrectly. In October 2016, a further inspection took place and some improvements around the management of medicines were seen though there were still some concerns identified.

At our last inspection in July 2017, we found the provider was again in breach of regulations for the safe management of medicines. This was because there were issues with medication storage, discrepancies with medicines administration and other records. 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. The safe domain was rated as 'inadequate.'

We received a provider report on the actions the service was taking. During this inspection we looked to see whether the provider had made improvements and were now meeting legal requirements.

This comprehensive inspection took into account the action the provider had taken to address the breach in regulation. At this inspection we found the hospice had made a number of improvements and this breach of regulation had been met.

At this inspection, the hospice was working closely with the medicines management team from the local CCG (Clinical Commissioning Group), the GP practice and pharmacy provider to improve the medicines arrangements in the hospice.

Two medicines inspectors looked at how medicines were managed at the hospice across the two units open at the service. We checked the medication administration records (MAR) for eight of the 17 people who were staying at the hospice. We inspected storage conditions and checked quantities of medicines for five people. We spoke with six staff and look at medication policies, documentation and audits.

Since the last inspection, the service had made significant improvements to the ordering and supply of medicines. A new pharmacy provider had been introduced to supply all medicines to the service. The pharmacy provided a seven-day service and delivered medication twice daily. The pharmacist had agreed to attend multi-disciplinary team (MDT) meetings fortnightly and evidence of this was seen at the inspection. All stock medicines, including controlled drugs had been removed and all medicines were supplied on an individual patient basis. Medicines' link nurses had been introduced with responsibility for ensuring that orders were placed and medicines received were accurate and timely.

We found that medicines were stored safely. The hospice had introduced individual bedside storage cabinets that were secure and helped to reduce the risk of administration errors. Daily temperatures were monitored to ensure medicines were stored correctly. Fridges on both units were checked daily and stored

medicines were within the recommended range of 2-8oC. We saw that people's enteral feeds were being stored safely on shelves in a locked room.

We looked at people's MARs on both units at the hospice. Photographic identification was not in place but the use of patient wristbands had been introduced. Not all people were wearing wristbands on the day of the inspection but the risk of errors had been reduced in other ways.

People were receiving their medicines as prescribed. There was evidence in records that daily checks were being done to monitor medicines for administration errors. Any errors found, were reported to senior staff following the local procedure. During the inspection, we found two errors with medicines that we raised and these were immediately investigated. All controlled drugs we inspected, were stored correctly and stock and records were accurate, there was evidence of daily stock counts being performed.

When medicines were prescribed 'when required' (PRN), additional information was available to help staff to give the medicine safely. These instructions had recently been updated but some lacked personal detail that would help staff to care for people.

We observed a person receiving their medicines straight into their stomach via a percutaneous endoscopic gastrostomy (PEG) tube. Records demonstrated that advice had been sought from a pharmacist regarding administration and fluid balance records were completed. Staff had received additional training to manage people with a PEG and Radiologically Inserted Gastrostomy (RIG).

We looked at topical application records and storage of creams and ointments. We saw the hospice had recently introduced records that included a body map that described where and how often to apply these preparations. Records were complete and the creams were stored safely.

All appropriate staff had undertaken medicine training and a supervised medication round. We saw staff had demonstrated competency in the last six months. The hospice had recently introduced a more detailed competency assessment and three staff had completed this at the time of the inspection.

Staff told us that that changes made to the management of medicines had made their medicines practices safer and they were now more accountable.

We asked people receiving in-patient care at the hospice and relatives if they felt the hospice provided a safe service. People's comments included, "Yes, the staff here are wonderful, I feel safe in their hands" and "It makes me feel safe staying here." Relatives we spoke with did not raise any concerns regarding their family member's safety and wellbeing.

We looked at how the units were staffed and this included reviewing staffing rotas, speaking with the staff on duty, people receiving in-patient care and relatives. We found there were sufficient numbers of staff on duty to keep people safe and to meet their individual needs. An 'escalation' tool helped 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 for people's care needs. A nurse appointed the role of 'compliance' checker was able to move staff around the units to ensure the right skills mix and numbers of staff were available to support people safely. Agency nurses were currently being used to fill gaps and provide cover in an emergency if required.

At the time of our inspection there were 17 people receiving in- patient care on two units. During our inspection there was an increase in staffing numbers to allow staff to attend engagement meetings that

were taking place. The normal staffing arrangements were as follows; for San Jose Unit, one registered nurse and four health care assistants (providing care for 10 people); for St Frances House, one registered nurse and three health care assistants (providing care for seven people). At night people received care from a registered nurse and health care assistant on each of these units. An in-patient manager worked alongside the registered manager to support clinical areas of practice. Ancillary staff included kitchen staff, domestic, laundry and maintenance staff. The hospice had a family support officer, volunteers who provided complimentary therapies two days a week, a site manager and a chaplaincy team for spiritual and religious support. The family support officer offered pre and post bereavement counselling for people, their relatives and staff.

There was an 'on call' system for 'out of hours' cover. Staff confirmed that the registered manager and in-patient manager were available to provide support in an emergency.

We looked at how staff were recruited and the processes in place 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. Evidence was available to show where staff were registered with appropriate professional bodies such as, the Nursing and Midwifery Council (NMC). The NMC regulate nursing staff and ensure professional standards; once nursing staff are registered they receive a pin number. These checks were carried out by the registered manager to ensure their registration was current. We saw records confirming this.

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. They also understood the concept of whistle blowing and said they were confident in speaking up. Training records showed staff had received safeguarding training and safeguarding training for managers was being attended by the in-patient manager and registered manager in January 2018. The hospice had reported actual or potential harm to the local safeguarding authority and agreed protocols had been followed in terms of investigating which helped to ensure any lessons could been learnt and effective action taken. This approach helped ensure people were kept safe and their rights upheld. A safeguarding referrals log was in place and any reported incidents were reported and discussed at the clinical governance meetings. We saw that the contact numbers for the local authority's safeguarding team were available along with the home's safeguarding policy. We had also been informed of safeguarded incidents in accordance with our statutory requirements.

A whistleblowing policy was in place. This encouraged staff to disclose any concerns without fear of repercussions. Staff told us they felt confident in speaking up. An equal opportunities policy helped to ensure all employees and job applicants were treated equally. Staff undertook equality and diversity training to protect against discrimination, as required under the Equality Act 2010. Care documents recorded information in respect of protected characteristics and other factors with people's involvement, so that individuals were treated with respect and dignity.

Risk assessments had been carried out to assess people's clinical risk, for example, the risk of developing a pressure ulcer, safe moving and handling, malnutrition and falls. Pressure ulcers are caused by 'sustained pressure being placed on a particular part of the body'. Dietary needs and nutritional requirements had been recorded and assessed routinely using an appropriate assessment tool (Malnutrition Universal Screening Tool – MUST). There were risk assessments for the use of bedrails to help mitigate risks and to protect people from unnecessary harm

Accidents and incidents were recorded, along with serious events, for example, a medicine error. These were

discussed at team meetings and clinical governance meetings. Emerging trends or patterns were identified and measures put in place to reduce risk. We saw actions taken in respect of increased risks for a person in respect of a change with their mobility. These were known and acted on by staff.

Systems and processes were in place to help ensure that the environment and equipment within the hospice were safe. Service contracts and internal monitoring checks were completed in accordance with the required schedules. For example, moving and handling equipment, fire prevention, legionella compliance, hot water, specialist mattresses and gas and electric service.

In respect of fire safety, a fire risk assessment was in place. Staff received fire prevention training and a number of staff were appointed the role of fire warden. A fire drill was undertaken in October 2017 and required actions were completed and lessons learnt shared with staff.

When we looked round the hospice we found it to be clean. Staff had access to personal protective equipment (PPE), such as aprons and gloves and we saw they used this when providing care. We were shown recent cleaning audits with a score between 75% and 90% for standards of cleanliness. In September 2017 an external auditor conducted an infection control audit and the service scored 92.5%.Three link nurses were appointed the role of infection control lead to help oversee the control of infection. This meant that appropriate action was taken to ensure the hospice was clean and the risk of infections or contamination limited.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in July 2017, we found that the provider was in breach of regulations and the effective domain was rated as 'inadequate.' The breaches identified were in relation to the hospice failing to consider consent for a person who was receiving covert medication, poor recording around care monitoring records, for example, fluid balance charts (for recording people's input and output), effectiveness of pain control, monitoring people on food supplements to ensure their health and wellbeing and providing appropriate staff support and appraisal.

At the last inspection we found failure to consider consent and whether a 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. This had placed the person at risk, as they had not been receiving medication which had been prescribed for serious medical conditions.

We found no reference to the use of covert medications in the policies and procedures at the hospice.

We received a provider report on the actions the service was taking. We were advised that 'The Covert Administration of Medication Policy has been written and would be operational by end of July 2017.

During this inspection we looked to see whether the provider had made improvements and were meeting legal requirements.

This comprehensive inspection took into account the action the provider had taken to address the breach in regulation. At this inspection we found the hospice had made a number of improvements and this breach had been met.

At this inspection we saw a new medicines' management policy was in place. It included management of covert medication administration, prescribing, self-administration and topical medicines application. We were provided with evidence that 36 staff had signed that they had read and agreed to abide by the new medication policy.

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 saw people had been involved in key decisions and their consent sought.

We inspected the records of a person that received their medicine covertly, hidden in food or drink. We saw documentation showing this had been agreed as being in their best interest. A pharmacist had advised the hospice how to disguise each medicine without reducing its effectiveness. There were no gaps in administration and stock was correct.

There was evidence of appropriate processes being followed where people had DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) notification in place. Staff understood about supporting people to make personal choices where ever possible. Staff told us about decisions made in people's best interests which ensured that proper and legal processes were followed in relation to the MCA and DoLS. Some decisions were not recorded as a best interest meeting and we discussed with staff ways of improving this record to evidence the process in which decisions were made.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Care files we viewed contained evidence that mental capacity assessments had been completed to establish whether people were able to provide their agreement and consent around key decisions. When people lacked capacity to consent, we found that an application to deprive people of their liberty had been made in their best interest. Any conditions recorded on the authorisation were reflected within people's plan of care and the registered manager was aware of the conditions. At the time of the inspection there were three DoLS authorisations in place and nine applications submitted to the local authority.

At the last inspection we found poor recording around care monitoring records. For example, fluid balance charts (for recording people's input and output), effectiveness of pain control and monitoring people on food supplements to ensure their health and wellbeing.

This comprehensive inspection took into account the action the provider had taken to address the breach in regulation. At this inspection we found the hospice had made a number of improvements and this breach had been met.

We looked at the fluid balance charts for five people and all were complete. An additional record had been introduced so that total daily fluid intake could be monitored easily. These charts helped to provide a good evaluation of the care provided. We also saw more detailed records around the treatment and management of pain to ensure people's pain was well controlled. Three staff were appointed the lead for dementia and work was in progress around sourcing tools and looking at areas of best practice to help record pain for people who had dementia or who had difficulties in communicating.

We checked the records for a person who was prescribed a fluid thickener to aid swallowing and reduce the risk of choking. The care record clearly stated the amount of powder that was required to thicken drinks properly, however staff still did not record when this was done. During the inspection the in-patient manager amended the fluid balance charts to include thickener quantity and informed staff that recording must now take place.

At the last inspection we found staff had not had an appraisal and not all staff had attended supervision meetings or had competency checks for clinical skills. We were concerned therefore that staff did not have the necessary competencies and skills to carry out care effectively.

This comprehensive inspection took into account the action the provider had taken to address the breach in regulation. At this inspection we found the hospice had made a number of improvements and this breach had been met.

All staff, including clinical staff and managers had a written appraisal and attended supervision meetings. Staff told us they were now given plenty of opportunities to discuss their training needs, professional

development and performance. Staff said they felt fully supported in the work place and setting appraisal goals helped to drive forward their learning and record their achievements. A staff member said, "The drive and desire to deliver excellent care was previously there but now it is renewed because of the training and appreciation of my skills."

Nursing staff received clinical supervision and this was overseen by a clinical supervisor. Clinical supervision enabled staff to focus on areas of clinical practice to develop competence; in turn providing high quality care based on best practice. We saw clinical supervision and appraisal training was given to senior staff, along with the registered manager and in-patient manager to support this area of practice.

The provider's action report informed us that a competency link nurse had been appointed and was working through competencies with the staff. We saw that clinical competency checks had been undertaken for different areas of clinical practice. For example, enteral feeding, medicine administration, cough machine technique, syringe drivers and catheter care. Staff told us these checks were ongoing so that their practices were monitored.

We looked at staff training. We saw staff received training to enhance their existing skills and knowledge thus providing safe, effective care. The provider's action plan told us, 'training will be ongoing and planned for one to two times a year to ensure staff updated with current research/best practice.

Since the last inspection all staff had received a comprehensive review of their education and training needs. Staff told us the training was very good and this helped to provide a 'better skill mix' on the units. We saw training records with identified training undertaken and planned training for staff in key areas. Staff had received training in 'mandatory' subjects such as, health and safety, medication, safeguarding, infection control, basic life support, moving and handling and fire awareness. Additional training was also provided in order to meet people's individual needs. This included, dementia care, wound care, percutaneous endoscopic gastrostomy tube (PEG) training, use of the MUST tool, management of epilepsy, tracheostomy care, importance of documentation and record keeping, staff accountability, Mental Capacity Act 2005, syringe driver training, route, cause and analysis, and Deprivation of Liberty Standards (DoLS). Discussion with the in-patient manager confirmed a rolling programme of training and future dates for further learning and mop up sessions for staff who had not attended previous training were evident. Staff told us how much they appreciated the training and education now given to them. A staff member told us, "There are so many courses available, I am getting the courses through all the time."

A member of staff was appointed the role of tissue viability link nurse to enable them to oversee the provision of wound and pressure ulcer care. The 'React to Red' training programme was being cascaded to the staff. 'React to Red' is a 'campaign that is committed to educating as many people as possible about the dangers of pressure ulcers and the simple steps that can be taken to avoid them'.

People who were receiving inpatient care told us they were happy with the standard of care and support they received. One person described the standard of care as 'wonderful'. Relatives also told us that they were pleased with the care and input by the hospice's medical team. A relative described the care as, "First class, absolutely brilliant."

Nursing cover was provided 24 hours a day on the units with the support of a local general practioner (GP) who was 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 the review and carrying out of people's health care needs was now consistent and effective. Health checks were undertaken and staff were vigilant in monitoring people's general health. A MDT meeting took place each Wednesday at the hospice and this was attended by the in-patient manager, in her absence the registered manager, a unit nurse along with the hospice's attending GP, palliative care consultant and pharmacist from a local CCG. Any required actions such as, a change of treatment/ medicines or hospital referral for a hospital appointment had been acted on promptly. Detailed notes were recorded at these meetings and people, relatives and staff informed of their outcome. Medical advice had been sought from other professionals, for example, dietician, physiotherapist, community matron and SALT team. Systems were in place to ensure people's needs could be met when they transferred between services, for example, for hospital appointments.

We looked in detail at the care and support of four people who were in-patients at the hospice. We saw a more detailed and consistent approach to recording care. This had been aided by a review of existing care documents and individualising peoples' plan of care. Key areas of care and risk were discussed at a daily 'safety huddle', with staff working closely with a nurse appointed the role of 'compliance' checker for the units. Staff told us that they felt assured by the measures take to identify people's health needs and emerging risks, so that appropriate actions could be taken to ensure people received effective care.

We reviewed a detailed plan of care in respect of a person's medical condition and the control of symptoms such as, pain, nausea and vomiting which could occur intermittently. The person told us that their symptoms were managed immediately and medical intervention was sought if required.

We viewed the care records for a person who had a tube for enteral feeding. Enteral feeding refers to the delivery of a nutritionally balanced feed via a percutaneous endoscopic gastrostomy tube (PEG). The PEG is passed into a patient's stomach to provide a means of feeding when their oral intake is not adequate. Staff were providing care which met the person's nutritional needs and also the care required for the PEG site/line. Care records seen showed a record of the enteral feeds and also care of the PEG site/line.

A number of people were nursed in bed due to their frailty and condition. People had equipment in place such as, pressure relieving mattresses and specialist nursing beds to help protect their skin and ensure their comfort. People appeared comfortable and settled. Staff attended to people's needs in a timely manner and staff completed daily notes regarding the care provision in accordance with people's plan of care.

We found that records relating to people's care and treatment were detailed, legible and were up to date. They reflected the care and support people required and were stored securely. Care files were accessible to all staff to ensure they had access to relevant information they required to enable them to support people safely.

People who were receiving in-patient care mainly wished to have their meals served to them in their room, rather than in the dining areas. No menu was available in people's rooms however we saw staff going round to inform people of the menu choices for the day; the menu being based over four weeks. People told us they were pleased with choice and standard of meals prepared. They went on to say the cook would always provide an alternative or 'whatever you fancied on the day'. On the day of the inspection people were offered Irish stew or spaghetti bolognaise with a choice of sweet. Hot and cold drinks and light refreshments were served throughout the day and there was also plenty of fresh fruit available. Relatives were invited to a Christmas buffet to celebrate the festive period.

We found the environment to be suitable for providing care for support for people at the hospice. This included adapted bathrooms and orientation aids. Equipment was safely stored and people had access to

garden areas that were well maintained.

Good

Is the service caring?

Our findings

At the inspection in July 2017, we found that the provider was in breach of regulations and the caring domain was rated as 'requires improvement.' The breach was identified as we found some concerns around confidentiality of people's care records. People's care notes were taken to the dining room by staff for annotation. This room was also used by relatives and confidential notes could be overlooked by relatives within this area. One relative we spoke at the inspection in July 2017 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.

We received a provider report on the actions the service was taking. During this inspection we looked to see whether the provider had made improvements and were now meeting legal requirements.

This comprehensive inspection took into account the action the provider had taken to address the breach in regulation. At this inspection we found the hospice had made a number of improvements and this breach had been met.

At this inspection we saw that confidential information was securely stored and we staff were making annotations to people's notes in the office or nurses' station. No communal areas were used for this purpose. Staff also told us about the importance of confidentiality, including how people's notes were kept secure.

People who were in-patients at the hospice told us the staff were kind, caring, respectful and compassionate. A person said, "The staff are so nice, wonderful how they help and nothing is too much trouble." A relative said, "The staff are marvellous and so attentive. I am really happy with everything."

Interactions we observed between staff and people receiving in-patient care were warm and familiar. We heard staff speak to people in a respectful way and were quick to offer support when needed. We observed staff supporting people with aspects of personal care; staff advised people of the support they were offering, provided reassurance throughout the support and ensured people's comfort before attending to someone else.

Through these observations and discussions with staff, it was clear that staff knew people well. Staff had a good knowledge of people's needs and how they wished their care to be given. A staff member said, "The patients' needs always come first." A person told us, "The staff here know exactly what help I need and they are always so helpful, nice and polite when with me. This reassures me."

On inspection we observed people's dignity and privacy being respected by staff in a number of ways. For example, we saw staff knocked on people's bedroom doors before entering and staff waited till they were told they could enter; people's preferred term of address and terms recorded in people's care files were respectful; and staff offered assistance to people with their meals in a sensitive and unhurried manner. Care files we viewed reflected that care was provided with dignity and privacy in mind. We saw that for a person

who had specific wishes around maintaining their independence long term goals for improving their mobility were recorded. The person told us they had been fully involved with this and staff respected their decision.

In respect of supporting people with limited communication or dementia, for example, the hospice had developed a dementia booklet and introduced a pain chart to help people communicate their pain by using pictures. A staff member was appointed as a dementia lead to help support the use of this new documentation and staff attended 'dementia friends' training,

There was plenty of information about the hospice for people to refer to. This included information about the 'hospice services and facilities'. A relative told us they had received lots of information about 'what a hospice was' and what to expect on admission.

People and relatives we spoke with told us staff talked to them about their care and support and decisions or changes in care or treatment were discussed with them. There was however limited information recorded in respect of people's or relatives involvement in the plan of care. We discussed with the registered manager ways of recording people's involvement in their plan of care.

We saw friends/relatives attending the hospice at different times and being made welcome by the staff. There were no restrictions on visiting and this helped people to maintain relationships that were important to them. Relatives told us the staff knew them well and one relative described the hospice as 'their extended family'. We saw staff offering relatives refreshments and relatives told us they had access to tea and coffee making facilities so they could help themselves. There were no specific facilities for relatives to stay overnight though relatives could stay if they so wished.

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. Where a person had appointed an attorney for health and welfare and/or property and financial affairs this was recorded in their care file to help support with decisions that needed to be made.

Good

Is the service responsive?

Our findings

At the inspection in July 2017 we recommended the provider complete a review of people's plan of care to ensure they provided sufficient detail and level of personalisation to assist staff to deliver more individualised care. Following the inspection the provider told us the actions taken in respect of making sure people's plan of care was personalised. This included care reviews and formulating new care plans where needed. A care plan provides direction on the type of care an individual may need following their needs assessment.

At this inspection we saw care records which showed people's plan of care was written in a way that reflected their wishes, preferences, needs and choices. We saw this in areas regarding people's routine, for example, time of getting up and retiring at night, people's preferred foods, social activities and how they wished their personal care to be delivered. The importance of such documentation is that it reflects a basic approach and values around treating people as individuals. Detailed information was recorded around people's medical conditions and actions needed by staff to monitor signs and symptoms. We saw an example of how care plan of care which showed how the staff responded to a change in person's mobility. This had been drawn up with the person concerned and provided good information about the person's independence and when they liked to rest. Care reviews had taken place to reflect any recent changes regarding care and treatment and to provide an ongoing care evaluation. External health professionals informed us that they had seen improvements around documenting people's care and support.

The hospice has a chapel for people to attend. Eucharistic ministers attended the hospice to administer communion to people who wished to receive it. The registered manager informed us that at the appropriate time they discussed people's spiritual and pastoral needs. This was also explored further for end of life care.

Since the last inspection more social activities have been offered to people receiving in-patient care. Some staff were involved with an activities group and arranging a calendar of events for 2018. A staff member told us how much people had enjoyed 'Play Your Cards Right' (card game) and a bingo session. They also informed us that plans were in place to introduce more complimentary therapies such as, aromatherapy. A person told us they enjoyed 'just chatting' with the staff and taking part in the card games.

During the inspection we saw that technology was in use to help support people and ensure their needs were met. For example, equipment was being used by the staff to help monitor falls and to reduce the risk of pressure ulcers. This equipment was provided in accordance with people's assessed need. The provider action report told us that yellow 'high risk of falls' wrist bands for people were in use to help staff alert them to this risk. People had access to a call bell to call for staff assistance. This helped to ensure that people's needs could be met in a timely way.

People receiving in-patient care and visitors to the hospice had access to the service's complaints' procedure. This was displayed in various parts of the hospice for people to refer to. People we spoke with told us they knew how to raise concerns and a relative said, "I have no concerns and know who to speak to if I was worried about anything." We saw complaints were logged and responded to in accordance with the

hospice's complaints' procedure. This included a recent complaint which had come to our attention and was investigated at board level. Outcomes from the complaints were shared with the staff for organisational learning purposes and to reduce the risk of re-occurrence.

With regards to the provision of end of life care there were no people who were being cared for at the hospice on a plan for end of life care. We however saw an example of a plan for end of life care that would be used at the appropriate time. We found this to be comprehensive and some of the wording used in the plan was altered during the inspection. This was to ensure it was 'fit for purpose' and in accordance with best practice for palliative and end of life care. A number of people who were receiving in-patient care had been involved with formulating an advance plan of care. An advance care plan records people's 'wishes, beliefs, values and preferences for their future care. We saw that for a person who did not wish to discuss advance care planning the staff had respected this decision.

The hospice had an end of life statement however there was no strategy in place to set out how this would be achieved. We discussed the development of this strategy including a plan of action and timescale to achieve the long term end of life care goals. The registered manager stated a strategy would be developed and a copy of the document sent to us once finalised. The hospice did not have the The Gold Standards Framework (GSF) in place though the registered manager informed us they were looking to introduce this in the near future to help develop end of life care. The GSF brings together the staff and as range of professionals/specialist teams from other settings to help deliver the highest standards of end of life care possible for people and their relatives.

There was a rolling programme for end of life training for staff and close working with other local hospices was evident. This helped to ensure people had a comfortable and dignified death. A number of end of life courses were mandatory and this included 'Opening the Spiritual Gate. Staff also were attending the Six Steps to Success in End of Life Care. We saw more training dates for 2018 and courses included, communication skills, training on advance care planning and the named course Introduction to Palliative Care and Essentials in Palliative Care. The registered manager attended recognised forums and workshops for end of life care and was booked on an end of life care conference in January 2018. We saw close working with other local hospices this included the hospice's nurses undertaking 'shadowing experiences' with a local hospice to 'expose staff to other clinical cultures'. Staff had access to guidelines and 'best practice' documentation to support end of life care. The National Institute of Clinical Excellence (NICE) for End of Life Care for Adults was also available for staff.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in July 2017, we found that the provider was in breach of regulations and the well led domain was rated as 'inadequate.' The breach was identified as we found ongoing failures by the provider to satisfy compliance as to good governance at St Joseph's Hospice. Systems and processes had continued to not 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 in-patient care.

The provider told us the actions taken in respect of improving the overall governance. The actions taken were recorded in a report which we received, a weekly report of the daily medication audits discrepancy and error analysis and a weekly report of the clinical compliance daily checks for the units. The clinical compliance report provided an over view of any emerging risks/critical errors and actions taken to mitigate these risks.

This comprehensive inspection took into account the action the provider had taken to address the breach in regulation. At this inspection we found the hospice had made a number of improvements and this breach had been met.

At this inspection we looked at quality assurance systems, including audits (checks) of risks, monitor performance and to drive continuous improvement. Previously the chief executive officer (CEO) had advised us of a clinical risk register to log and track specific clinical risks, new clinical tools such as, the 'escalation tool', audit tools for medicine management and a revised internal HR system and processes to ensure fair, consistent and equitable treatment of staff. At this inspection we were able to see and therefore report on these areas and how systems and processes had been further developed with input from external professionals and specialist teams and HR to provide a consistent, safe, effective and well led service.

We saw robust auditing of clinical practice, safeguarding, compliance, health and safety, infection control, medicine management, care planning, significant event analysis and complaints. A staff member was appointed the lead for reviewing care documents and the changes made had resulted in people having a comprehensive plan of care. A number of care documents had been recently reviewed by an external clinical quality team who had reported favourably regarding the changes and standard of documentation now in place. A staff member was appointed the documentation lead and continues to work with staff to make further improvements and to comply with the recommendations made by the external clinical quality team. We saw that the clinical compliance checks instigated following our last inspection were now seen as 'business as usual' and were continuing; these were seen as a valuable tool for overseeing clinical compliance. The three C's (care, comfort and communication) checks provided staff with a prompt, "Is there anything else I can do for you", to ensure people's comfort and wellbeing.

We looked at how medicines were monitored. Since the last inspection, the service had undertaken daily internal and bi monthly external medicines audits and reported findings to us, the Care Quality Commission (CQC) as requested. We saw the number of errors had significantly reduced and analysis and actions were

taken to mitigate the occurrence. Some errors were due to supply issues, prescribing problems and some were documentation issues. Safeguarding referrals were made when appropriate and families informed. The registered manager took appropriate action and kept the relevant agencies informed. Errors were raised at clinical governance meetings and lessons learnt were shared with staff to lessen the risk of re-occurrence. It was found that a large number of errors involved agency staff and actions were taken to address this.

The service had a registered manager and they were on duty at this inspection. They were supported by the in-patient manager and full complement of staff. We found the culture of the service to be open and transparent. Staff we spoke with told us the registered manager was approachable and dealt with any issues they raised. Staff also told us the staff team worked well and felt fully supported. Staff morale was now positive and staff were complimentary regarding the changes that had been implemented over the last five months. They told us communication had improved and one staff member stated, "We all feel we have turned a corner." Another staff member referred to the new management as a 'breath of fresh air'. Staff told us they felt valued and appreciated by the managers and 'things were much better' now. Staff also said they felt they were 'making a difference' and their contribution was appreciated. A staff member said, "I am really proud to work here."

Staff told us that the registered manager and the in-patient manager visited the units and often attended staff handovers so they were kept up to date regarding people's care. It was evident that the registered manager had a visible presence on the units; this was confirmed also by the people receiving in-patient care and relatives we spoke with.

The governance structure for St Joseph's Hospice was clearly defined. Seven members formed the Board of Trustees and they attended quarterly meetings and an annual general meeting in December of each year. The meetings provided a platform to discuss the hospice's performance and development, and to provide an over sight around people's safety and patient care. The agenda for these meetings continued to place emphasis around people's care and safety and areas such as, safeguarding, risk management, information governance, regulation, drug errors/concerns, serious incidents, mandatory training, service quality, partnership working with external professionals and providing data for Commissioning for Quality and Innovation (CQUIN) national goals. 'The CQUIN scheme (NHS England) is intended to deliver clinical quality improvements and drive transformational change. These will impact on reducing inequalities in access to services, the experiences of using them and the outcomes achieved'. Any matters arising and discussed at the clinical governance meetings, had actions set, with target dates for completion and person responsible for the actions. The minutes seen provided a detailed over view of how the hospice and any emerging risks or concerns were highlighted. Required actions were dealt with promptly and outcomes shared with the staff. The registered manager informed us that the trustees regularly attended the hospice to meet people, their relatives and staff and these visits had increased since our last inspection in July 2017.

The registered manager told us about the development of link nurses, for example a link nurse for nutrition and PEGs, medical devices and clinical competencies, safeguarding and DOLS, falls, incident reporting, infection control, dementia, dignity and medicine management. The aim of a link nurse to support staff learning and 'best practice'. A staff member told us how this had helped with the management and accountability with medicine practices. The provider had a range of policies and procedures available to help guide staff in their practice. These were subject to ongoing review so that information was current and in line with best practice.

The registered manager told us about the benefits from the MDT meetings and how invites to these will be extended to other external professionals to help strengthen the meetings. Other areas of development included establishing a clinical supervision system for the GP who attends the hospice with 'shadowing'

sessions from the hospice's palliative care consultant. Staff told us that the development of the MDT meetings had helped provide a robust clinical oversight of people's current conditions and treatments.

We saw close working with external professionals. This included local commissioning groups, safeguarding teams and us, the CQC. The registered manager has worked closely with us regarding the improvements, demonstrating determination and motivation to provide a well-run service. The hospice were signed up and had appointed a link nurse for The Care Home Innovation Programme (CHIP) to improve the quality of the service.

At the time of the inspection staff were attending staff engagement sessions to discuss the hospice's mission, values and to report on how effective the changes were. The registered manager was able to tell us that the feedback had been very positive from these sessions. Staff told us they attended monthly staff meetings and they were able to share their views. They also told us that information was cascaded to them in a timely manner and they felt fully supported. To support agency staff who worked at the hospice, agency induction forms providing an over view of the service had had been introduced. Staff surveys were due to be sent out early in 2018 to gain further staff feedback.

The registered manager informed us of future developments for the hospice. This included building on the volunteer force and recruitment of nurses including appointment of a senior quality assurance nurse; an in house coffee shop for people receiving in-patient care and visitors; an occupational health service for the staff; and extended the variety of social activities. We saw staff training was ongoing and future training included key staff undertaking a trainers' course to enable them to provide manual handling training and a phlebotomy course. Staff told us they were looking forward to undertaking these courses as part of their professional development.

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' where people and their relatives could leave feedback about the service. We also saw compliments recorded on thank you letters. Feedback was very complimentary regarding the overall service provision. A letter received by the hospice, included the following comment, "Thank you all so much, you are exceptional people dealing with a very difficult job, but it is always done with a smile and kind word." During the inspection a person told us the hospice staff were "Just amazing."

Our organisation, the CQC had been notified of events and incidents that occurred in the service in accordance with our statutory notifications. This helped us 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.