St Lukes Hospice

St Luke's Hospice

Inspection report

Little Common Lane
Whirlowdale
Sheffield S11 9NE
Tel: 0114 236 9911
Website: www.stlukeshospice.org.uk

Date of inspection visit: 12 & 13 August 2014
Date of publication: 09/04/2015

Ratings

Overall rating for this service	**Good**
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

The registered manager who was also the deputy chief executive officer was in charge of the day to day running of the hospice. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

St Luke's hospice provides care and treatment for up to 20 inpatients and people in the community alongside of their GPs and the community professionals. They also provide day service which is out of our scope for registration to help people and their relatives.

We found the services provided by St Luke's hospice including community service, day care service and the

Summary of findings

inpatient service to be well led. The management team promoted innovation and encouraged staff and people who used the service to take part in improving the service.

The environment looked clean, comfortable and well maintained. People had access to communal areas and to quiet areas when they wanted to. Visitors were not restricted and they were able to stay and support patients. There were 20 inpatient beds which comprised of 14 single en suite rooms and two three bedded en-suite rooms. There were no mixed sex bays and relatives' facilities were good. During our inspection there were 16 inpatients.

Staff who worked within the service demonstrated competence, commitment and compassion. There were sufficient numbers of staff to meet the needs of people. People had access to therapy staff. The cook visited people each day to find out their requests for meals. This was well received by the patients.

There was a robust recruitment process and staff had attended induction when they started work. Staff told us that they received support and supervision from their line managers. Staff who spoke with us fully understood their roles and responsibilities, as well as the values of the hospice.

People received person centred care which put them in the centre and took into account their wishes and therefore people felt they had been included and listened to.

The registered manager used the findings from the quality audits to monitor the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

This service was safe because people and their relatives told us that doctors and nurses always discussed the treatment options and explained what was involved which made them feel safe.

There was rigorous recruitment, induction and staff training which made sure staff were competent in following the procedures, including safeguarding, capacity and people's best interest to ensure safety of people.

The provider had taken appropriate action to ensure only authorised people had access to the service.

Is the service effective?

Good

This service was effective. The 'Patient's Handbook' was offered to people and relatives at the first visit which provided information about the hospice, the facilities and support offered.

People used the service to achieve better symptom control. The issues could be relating to physical or emotional symptoms. Therapy staff and medical staff assessed and treated people so that their systems were under control as much as possible.

The environment had been adapted and appropriate facilities had been provided to meet the individual needs of people.

Is the service caring?

Good

This service was caring. People and relatives said that they were listened to and felt staff understood what was important to them.

People were able to inform the staff of their advance decisions and they said they could express preferences and choices for their end of life care. They said they were happy the discussions were documented and therefore would be passed on to other staff. We observed information share amongst staff at handover sessions.

Staff made sure the care was centred around the person so that consideration was given to individual's needs in respect of age, gender, race and religious beliefs when planning and delivering care and treatment. We observed such discussions when we attended multidisciplinary meetings.

Is the service responsive?

Good

This service was responsive. People were encouraged and supported by staff to express what was important to them so that staff were able to offer a treatment plan which was suitable for their needs. For example a person went home to be with their family during the weekend and this was accommodated in the planning.

All comments by people and visitors were taken seriously and staff dealt with them promptly.

In response to the suggestions of people and their relatives , work has commenced to redesign the garden so that the outdoor space could be used effectively by patients and relatives.

Summary of findings

Is the service well-led?

Good

This service was well-led.

To drive continuous improvement a robust quality assurance and clinical governance system was used. St Luke's hospice used a '15 step challenge' to monitor their service. The '15 Steps Challenge' encourages patients and staff to work together to identify improvements which may enhance the patient experience, highlighting what was working well and what might be done to increase patient confidence.

We gained feedback from patients, relatives and visitors through telephone conversations, talking to people in their homes and speaking to people at the hospice. We found that there was a strong sense of support and caring within the hospice and that people received care which was centred on their individual needs..

The management team made sure consideration was given to outcomes of audits carried out in the service and the results from the analysis of incidents and complaints to implement changes. For example there had been an incident of a person developing a pressure sore. The route cause had been investigated and action had been taken through staff training and making staff aware of the importance of documenting evidence in a timely manner.

St Luke's Hospice

Detailed findings

Background to this inspection

We inspected St Luke's Hospice on 12 and 13 August 2014. The first day of the inspection was unannounced which meant the staff and provider did not know we would be visiting.

The inspection was led by an adult social care inspector who was accompanied by a specialist advisor and an expert by experience. A specialist advisor is someone who has up to date knowledge and experience working in a specific field. The specialist advisor who took part in this inspection had extensive knowledge and experience in palliative care. Palliative care is a holistic, multi-disciplinary approach to providing patients relief from the symptoms, pain, and stress of a life limiting illness. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience in supporting people with end of life care.

Before we visited the hospice we checked the information we held about the service such as the notifications, safeguarding referrals, enquiries and information from the public through our web form 'Share your experience'. We analysed the Provider Information Report (PIR) which was submitted by the hospice before our inspection. We also contacted the local clinical commissioning group to find out their views about the service. No concerns were raised from the information we gathered about the service. The last inspection was carried out on 30 July 2013 and the service was found to be compliant with the areas of regulations we inspected.

At this inspection we sought the experience of people and their relatives about the service as inpatients and about the support they received at home from the community palliative care nurses who were supplied by St Luke's . We visited three people at their homes with their permission and we were accompanied by one of the community palliative care nurses. We contacted three relatives and two people by phone at their homes after consulting with staff and also informing them beforehand about our phone call contact. We also spoke with five relatives and eight people at the hospice during our inspection.

We conducted structured one to one staff interviews of ten staff which included the specialist palliative care consultant, the bereavement counsellor, two doctors, pharmacist, two nurses and the senior sister for inpatients. We viewed the medical and nursing records of four people who were inpatients; we looked at seven staff files which included ancillary staff and multidisciplinary staff such as medical and nursing staff.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

During our inspection we observed good and sensitive staff interactions with people. All staff including reception staff made sure when people arrived at the hospice they were asked to identify themselves and signed a book to say who they had come to see. This ensured the safety of people who were at the hospice.

People were shown or accompanied by appropriate staff to ensure people arrived safely at the point of destination. Key fobs were used to access all doors to patient areas. This ensured that only authorised people had access and therefore maintained safety of people and staff

We observed staff demonstrating a good understanding of safeguarding procedures. Social workers were employed by the hospice to ensure safeguarding referrals were appropriately managed. In the last 12 months there had not been any safeguarding referrals made to the local authority by the patients or staff at St Luke's. During our inspection we did not see any evidence of safeguarding issues.

Staff told us that they had training on safeguarding people from harm and abuse. They said often people felt vulnerable due to their illness and needed assurance of their safety. Two staff who spoke with us said that the side effects of medicines sometimes affected people's perception of what was happening to them. Therefore, people needed to be given plenty of reassurance to make them feel safe and make sure relatives were kept well informed so that they were assured of the safety of patients. One staff member said, "Sometimes patients become challenging, we deal with it in a safe manner so that they feel they are protected and safe".

Three inpatients told us staff made sure they were safe at all times. Day centre patients we spoke with said they were busy with activities and they were well supported by staff prompting them to take their medicines on time and offering them food and fluids. They said if they needed medical attention one of the doctors looking after inpatients would see to them. One person said, "The medicines sometimes make me wobbly and staff are very good at warning me and stopping me from falling". A relative told us that all staff including medical staff were mindful of keeping people safe. They said, "They always make sure bedrails were put back on after examinations".

This meant staff ensured patients were safe. When we looked at care files we noted people who were at risk of falls has a risk assessment which detailed the action to be taken by staff to maintain safety.

We checked staff records and analysed the PIR to find out the status of staff training in safeguarding vulnerable people, Mental Capacity Act 2005(MCA) and Deprivation of Liberty Safeguards (DoLS). We noted there were gaps in staff training. However, the registered manager informed us that they had commenced training for staff and this had been addressed.

Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 (MCA) legislation which is in place for people who are unable to make decisions for themselves. The legislation is designed to ensure that any decisions are made in people's best interests and the least restrictive option is taken. We found staff considered people's capacity and consulted about the use of DoLS at multidisciplinary meetings. This was to make sure that where people lacked capacity to make decisions these were made in line with legal requirements and in their best interest.

Staff told us they had effective channels of communication and felt supported within their role to raise any concerns if required.

Staff told us they had seen the procedures and received training on how to respond to major incidents including medical emergencies and untoward events such as fire or floods. The manager informed us that they did not have an automated defibrillator at the hospice. It would be useful for the provider to refer to the UK Council resuscitation guidelines

Patients' records were kept securely and people and their relatives were able to access them if they needed to. When reading patients' care plans it was difficult to ascertain who was for resuscitation since this was not clearly recorded in patients' notes. However, we saw such information was included in staff handover notes. This meant there was a mechanism in place to ensure staff knew people who were identified as not for resuscitation.

Staffing levels were assessed and monitored to ensure they were sufficient to meet people's identified needs. There was 24 hour medical and nursing staff cover at the hospice. The service ensured appropriately skilled, experienced and qualified staff were employed so that the care and

Good

Is the service safe?

treatment patients received was suitable and safe. At the time of inspection there were 16 inpatients and a nursing staff ratio of 1:6; this was within set national levels. The number of support workers allocated for shifts depended on the dependency levels and the occupancy of inpatients This meant the provider had a sufficient number of staff to meet the needs of patients.

People in the community received advice and support from St Luke's community palliative care nurses and from their GPs. There were effective lone working arrangements in place for staff to maintain safety in community. We visited three people in their homes with the community palliative care nurses. People were informed of their appointments in advance, however nurses called people on their phone before they entered the home as an additional measure of safety.

Good

Is the service effective?

Our findings

People and their relatives confirmed they were involved in the assessment and the planning of treatment processes. We saw the treatment plans which were evidence based; this meant people were offered treatments which were effective and appropriate.

People and relatives who spoke with us said that the main aim was to achieve better symptom control. They said that it was usually their pain control. One person and three relatives said symptom control took some time. They said once pain is controlled then they became very sleepy and felt they were wasting their life. This meant they "had to reach a happy medium where they are awake, know what is happening and free of pain." One relative said "This is asking too much, but doctors and nurses eventually get there. I appreciate their work". We received a comment that nursing staff were not always responsive in time to address people's pain control. This was shared with the respective staff. However, during our observation we saw nursing staff responding to patient's calls and addressing their requests promptly and appropriately. We checked two patient's records and found they had been administered pain relief at regular intervals. A pain monitoring chart was in place and appropriate analgesia was given.. We conferred with staff about giving consideration to patients' perception of pain and other contributing factors.

We were informed by staff when patients were initially referred to the hospice they were asked by them about person's preferred place of care. If they chose to be an inpatient, if possible people were offered single rooms. There were no mixed sex bays and relatives' facilities were good.

People and their families were provided with information about the service when they were admitted. We were informed that if people needed the information in a different format this would be arranged without any difficulty. The information included a welcome pack known as "The Patient's Handbook; All you need to know about being an in-patient at St Luke's! which provided information about the hospice, the facilities and support offered. The information pack was updated regularly to reflect changes made to the service. Two relatives told us that the information pack was very useful. One of them said, "It was all too much on the day to take in. I took the information home and read through. It was all in sections and easy to read. Well done to St Luke's". People who attended out-patients and those who were supported in their own homes also received information which they found informative and useful.

As part of care planning, people were asked for their preferences and choices of food. Patients' hydration and nutrition were assessed and records were maintained to ensure patients were in receipt of sufficient food and drinks. Food supplements and snacks were also offered to people who had difficulty eating a meal. Meal times were extended to meet the preferences of people. A person centred approach meant there was no set meal times and patients were able to have a meal at any time in the day. We saw people having meals in the dining areas and some people chose to have their meals in their own rooms. Two people complained about the "menu being the same" and food not "plain enough" and little choice after 8pm at night. But two other patients, all the staff we spoke with and three relatives said food and hospitality was exceptional. One relative said, "I cannot fault it. It's marvellous here. It's like a five star hotel". We shared our finding with the appropriate staff. During our inspection we saw tables set with tablecloths and cutlery. Day patients had protected meal times within the therapy centre. Protected meal time is designed to allow patients to eat their meals without disruption and enable staff to focus on providing assistance to those patients unable to eat independently.. People's likes and dislikes of food were recorded and the kitchen staff had a copy of the record. We saw people were able to change their minds and ask for a different choice of meal and the catering staff prepared it for them.

Good multidisciplinary team working was displayed within the inpatient unit and therapy unit. A transfer of care nurse facilitated and coordinated the care when patients were admitted and/or discharged from St Luke's.

A seven-day service of rapid response was offered to people in the community by St Luke's. A group of experience nurses and support workers were able to be called upon to provide support in the community. When people had been inpatients they called the hospital for help at the latter stages of their life and the staff who worked in the rapid response team were able to help people. This was to help people stay in their homes as long as possible and also to support people who wanted end their life care at home. It was noted that the rapid response

Good

Is the service effective?

service was suspended for four weeks at a time of high annual leave. People told us that they found the rapid response service very helpful. The registered manager told us they were looking into reviewing the service due to its demand.

Good

Is the service caring?

Our findings

We observed patients receiving person centred and individualised care. Person centred care means creating a collaborative relationship where people are supported to make informed decisions and manage their own health and care to achieve the outcomes they want. Relatives told us that staff were very caring and showed compassion. One patient said, “Doctors and nurses are there for me and my family. They listen to my worries and help me the best they can. Therapy staff are wonderful”. A relative said, “Not everyone could work in this environment. These staff are special, kind and understanding of our concerns”.

We saw letters and ‘thank you cards’ from relatives following the death of their family members. The messages were in appreciation for the care and attention their family member received. Some relatives worked as volunteers at the hospice to offer their help and show their appreciation of the care. Two volunteers who spoke with us said they were like the ambassadors for the caring work by St Luke’s.

Relatives and staff told us that people were given information and explanations at the time they needed it. They said it was carried out by the most appropriate staff and in a sensitive manner. One relative said, “It is very difficult when they ask how long have I got. Staff seem to know how to break such news. They are good at preparing people and giving them emotional support”.

Staff had received training on promoting equality, maintaining diversity and human. This meant through person centred care, people’s needs in respect of their age, gender, race and religious believes were respected and taken care of. We made the following observations during our inspection. At the reception area in the main entrance of the hospice there were two large doors which lead into the chapel for all faiths. The doors were kept open people used the room to reminisce or as a quiet room with their families. Children were able to bring in toys and letters to remember their parents and leave them there.

We saw the facilities that were available for relatives of multifaith patients to enable them to carry out any religious rituals to fulfil their religious beliefs.

We observed the hospice offered an extensive patient and relatives support service, which included psychological support, bereavement counselling, giving support through telephone i.e.'Tele health' support, bereavement support groups and emotional support. Staff promoted good communication and they were skilled in speaking with people about sensitive subjects. The records indicated patients were involved and staff had made sure patients understood their treatment plans. We saw staff speaking with patients in private and maintaining their privacy and confidentiality.

Staff told us that most patients had representatives who were their relatives or friends, however if anyone needed an advocacy service, they knew how to organise it. The care records we looked at had names and contact numbers of people’s next of kin. This meant staff were able to contact relatives without delay.

Patients and relatives told us that medical and nursing staff always discussed treatment options and involved them when deciding on their treatment plans. They said they were able to take time and ask questions about the proposals and they felt they were listened to by the doctors. We attended two multidisciplinary team meetings where staff discussed patients’ treatment plans and progress.

Good

Is the service responsive?

Our findings

The multidisciplinary staff team was responsible for identifying and treating people's needs in a timely and appropriate way. We found people were encouraged and supported by staff to express what was important to them. This meant people were able to receive tailor made care to suit their circumstances. One patient and their relative said the doctors and therapy staff worked well together to reduce the negative impact on the family caused by the illness.

People were given opportunities to express their views about their health, illness and the quality of life outcome they wanted through their advanced decisions. People's wishes about end of life were taken into account during the assessments and when planning their treatment and care. These were recorded in their care plans. Doctors and nurses told us that people's decisions changed with the progression of their illness. Therefore, each week during multidisciplinary team meetings they discussed how the patient had been so far, how they had responded to the treatment and the treatment options available to them; before they approached the patient to consult with them. This meant when patients told the doctors their issues and wishes, the staff would be able to respond effectively.

There was an open, inclusive and a listening culture among all staff who worked at the hospice. This meant people, relatives and visitors were able to make comments about the service. Staff said every comment was taken seriously and dealt with as quickly as possible. All formal complaints were recorded and investigated by the appropriate departmental head and records were maintained. Departmental heads explained when complaints were investigated, the outcomes were discussed at governance meetings and managers informed staff of the lessons learnt. This was to make sure such complaints were avoided as much as they could be in the future.

We informed the catering staff and the manager about a comment from two people. They said although food was excellent there was nothing available to eat after 8pm. This information was investigated and we were informed that the ward kitchenette had facilities to prepare snacks, but not all the people were aware of this. They said people would be offered snacks by night staff to ensure people knew they could get snacks or even a meal if they wished. This shows that comments were listened to and responses were prompt.

Service planning and delivery was based on the needs of local people. There has been extensive service development with public consultation. People we visited in their homes were full of praise about the service the community palliative nurses delivered and how this helped them to stay at home and cope with their illnesses. People told us about the 24hour cover provided by St Luke's and the benefits to them. The registered manager confirmed that they provided senior nurse cover and medical registrar cover during the night to support other staff.

Multi professional referral meetings were held to triage/ manage all referrals to the hospice services. These meetings helped to prioritise the admissions and also decide the best place for the person to receive the appropriate treatment with suitable support. Therefore the waiting list for inpatient services was small with just one patient on the waiting list at the time of our inspection.

When people were discharged into the community, a nurse was in charge of the arrangements. This included specified details in discharge summaries and people's personalised care plans to inform their GP and the community professionals to ensure continuity of treatment and care. The nurse in charge of transfer of care told us that she was available to help with information to achieve a seamless service.

People and their visitors had been asked for their suggestions to improve the service by the staff. People had identified priorities and they had been included in an action plans for 2014-15. An example of this was the redesign of the garden area and the development of a garden room. We saw that work had commenced and the plans would give people and their relatives a very pleasant area to relax and enjoy.

Bereavement care services were well led and co-ordinated by the bereavement counsellor. Relatives were able to make appointments and meet with the counsellor. We saw the counsellor approaching people and making themselves known so that they were accessible to people. We were informed that for reference and audit purpose all counselling sessions were recorded.

Good

Is the service well-led?

Our findings

At the time of our inspection there was a manager in post at the service who was registered with the Care Quality Commission. When speaking with staff and the departmental heads including the palliative care consultant, we noted there was a clear future plan for St Luke's hospice. This was shared with people who used the service and those who worked at St Luke's Hospice. The registered manager demonstrated a true leadership by promoting 'one team' culture within the service so that all workers took ownership of their responsibilities and worked as a team. The registered manager carried out daily 'Patient safety walk about'. This meant the registered manager made themselves accessible to patients, relatives, visitors and staff each day and in doing so had first hand knowledge of what was happening at the hospice.

There was a risk manager who demonstrated a clear understanding of their role. Staff said the risk manager was approachable and very helpful when they identified problems. One staff member said, "He is like a second pair of eyes who can see things objectively and help us make the right decision." We observed the risk manager helping a staff member to report an incident and enabling staff to follow the procedure and explaining why this had to be done. Following that staff we saw staff completing the necessary actions.

There was a robust quality assurance and clinical governance system in place which was used to drive continuous improvement. St Luke's used 15 step challenge to monitor their service. The 15 Steps Challenge encouraged patients and staff to work together to identify improvements which might enhance the patient experience, highlighting what is working well and what might be done to increase patient confidence.

Management took action by following up incidents and implementing changes. We saw evidence of learning from incidents and accidents. For example, an incident related to the loss of codeine tablets from pharmacy. The lock on the pharmacy door was affected by a power cut for 50 minutes. This was reported and investigated and a secondary lock was put in place. They had also introduced a CCTV in the inpatient unit where controlled drugs were stored.

Feedback from patients, relatives and visitors highlighted that there was a strong sense of support and caring within the hospice and that people received a person centred service. There were comments about the "excellent" support by the community palliative care team.

Our observations highlighted that there was a long established community team with a wealth of experience that may benefit from further integration. This could be achieved through rotational working of community team with in-patient staff. The manager said through rotation they would be strengthening the support for the nursing leadership within in-patient activities. They agreed it would give junior staff career stretch opportunities and work alongside experienced staff. This meant patients would benefit by staff who are supported by experienced staff.

We saw a range of audits carried out by departmental staff. These included health and safety, infection control, fire safety, environmental risk assessments and maintenance of equipment. The findings were analysed and staff were informed at staff meetings of the outcome of the audits and any actions they needed to take to make improvements. This was confirmed by staff.

The recent staff survey results were shared with us. The survey showed that the staff were motivated, caring and supported by their managers. Staff were aware of the learning and development opportunities for them.