St Clare's Hospice

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 22 January and 30 January 2018 and was announced. This meant the provider knew prior to the inspection we were due to visit the hospice. St Clare's Hospice provides in–patient care for up to eight people with life limiting illnesses. At the time of our inspection four people were staying at the hospice.

At the last inspection in July 2016 we asked the provider to take action to make improvements to medicines management and good governance. Following the inspection we asked the provider to complete an action plan to show what they would do and by when to improve the key questions; is the service safe, effective and well-led to at least good. We found during this inspection significant progress had been made towards completing these improvements.

Medicines administration records were accurate. However, we found further improvements were required to evidence people had been included in discussions about using medicines off-licence and to ensure medicines prescribed for other people did not continue to be used. We also found people were not fully protected against the risks associated with medicines because appropriate arrangements to oversee the management of medicines needed further development. The provider had made significant improvements to strengthen the governance arrangements in the hospice. For example, the provider had developed a structured approach to supporting staff and systems to implement robust quality audits.

The hospice 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 in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People said they received good care at the hospice from a kind and caring staff team. The provider received a significant number of compliments from people and relatives praising the care provided at the hospice.

Staff had no concerns about people's safety. They showed a good understanding of safeguarding and the provider's whistle blowing procedure. Staff told us they would have no hesitation to raise concerns if required.

Staffing levels were sufficient to meet people's needs. People told us staff responded quickly to their requests for help. They also said they saw a doctor every day. Staff confirmed staffing levels were appropriate.

The provider completed a range of pre-employment checks to ensure new staff were suitable to work at the hospice.

Regular health and safety checks were carried out help keep the hospice and equipment safe. For example,

checks of fire, water, gas and electrical safety. The emergency procedures were currently being reviewed and updated.

Incidents and accidents were investigated and action taken to help keep people safe.

Staff told us they were well supported and received the training they needed.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

Staff supported people with their nutritional needs in line with their assessed needs. The hospice medical team were available to plan and meet people's care and treatment. People confirmed they saw a doctor at least every day.

People's needs had been fully assessed which included discussing their hopes and preferred outcome from their stay at the hospice. Care plans were in place but these continued to be generic with very little personalisation to the needs of each person. We have made a recommendation about this.

Care records recorded people's wishes for their future care needs, such as their preferred place of care.

The provider gathered feedback from people using the service through various surveys. They were in the process of gathering feedback from bereaved relatives.

The day hospice programme had been totally revamped since our last inspection and was implementing a "Living Better" programme focussed around people's wellbeing and self-management of their symptoms.

People only gave positive feedback about their care. The provider had a structured approach to dealing with complaints about the hospice. One complaint had been received since the last inspection. This had been fully investigated and resolved.

The opportunities for staff to meet had improved since the last inspection. Staff meetings were now taking place.

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 not always safe.

Further improvements were needed to manage medicines appropriately.

People and staff said the hospice was a safe place.

Staff showed a good understanding of safeguarding and whistle blowing, including how to report concerns.

There were enough staff to meet people's needs. Effective recruitment checks were in place.

Health and safety checks were completed and procedures were in place to keep people safe in emergency situations.

Is the service effective?

Good

The service was effective.

The provider had developed a structured supervision and appraisal process.

Staff received the training they needed.

The provider followed the requirements of the Mental Capacity Act (MCA) 2005.

People were supported to with their nutritional and healthcare needs.

People had access to medical assistance at all times.

Is the service caring?

Good

The service was caring.

People told us they received good care at the hospice.

People were treated with dignity and respect and staff promoted their independence.

Support was available to help people with their emotional and spiritual wellbeing.

Is the service responsive?

Good

The service was responsive.

We found care plans were still generic and had not been personalised.

People's needs had been fully assessed and their views, preferences and wishes discussed.

The services provided in the day hospice had been revamped.

People gave us only positive feedback about their care. Previous complaints had been fully investigated and resolved.

Is the service well-led?

Requires Improvement

The service was not always well led.

Although a plan was in place to review policies and procedures, this had not yet been completed.

The new quality assurance process had been developed and was due to be implemented from April 2018.

Staff told us the management team were approachable and supportive.

Since our last inspection opportunities for staff to share their views had improved.

There were opportunities for people to give feedback about their experience of the hospice.

St Clare'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 inspection took place on 22 and 30 January 2018 and was announced. The provider was given 48 hours' notice so as not to disrupt the day-to-day running of the service and to enable nursing staff, who were caring for very unwell people, to be available to speak with us.

On the first day of this inspection there was one inspector and a pharmacist inspector. On the second day of this inspection there was one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we reviewed the information in the PIR as well as all the information we held about the service, this included notifications of significant changes or events.

Prior to the inspection we contacted external commissioners of the service from the Clinical Commissioning Group (CCG), the local authority safeguarding team and the local Healthwatch. We used their feedback during the planning of this inspection.

During our inspection we spoke with two people of the four people staying at the hospice. One person was too unwell and one person chose not to speak with us.

We also spoke with a range of staff including the chief executive, the registered manager, two hospice physicians, two nurses and two health care assistants. We reviewed a range of records including five people's care records and people's medicine records. We also reviewed five staff files, training records and other records relating to the quality and safety of the hospice.

Requires Improvement

Is the service safe?

Our findings

When we last inspected the hospice we found a breach of regulation relating to managing medicines. During this inspection we looked at how medicines were handled and saw appropriate arrangements were in place for checking and confirming people's medicines on first admission to the hospice. When people were discharged we saw detailed information about their current medicines, including changes made during their stay in the hospice, were given to them. This ensured up-to-date information about medicines was available to the person's GP, if required.

Appropriate arrangements were in place for the recording of medicines. Medicines were prescribed by the in-house medical team. The medicines that were prescribed on an 'as required' basis included instructions for how frequently these medicines could be administered and the maximum doses allowed. All people were receiving their medicines as prescribed.

Prescription pads were stored securely and there was a system in place to monitor their use. There was a system in place to deal with safety alerts and recalls of medicines. Emergency medicines were easily accessible to staff and all staff knew of their location. All medicines we checked were in date and suitable for use.

The use of medicines outside their license is widespread within palliative care and it is when a medicine is being used differently to how the company manufacturing the medicine intended. When medicines were used outside their licence, there was no record that this was discussed to allow people to make an informed choice about their treatment.

The service had systems in place to ensure people's medicines were safe and fit for purpose; however these were not always effective. We saw that a lockable cabinet was located in each room for the secure storage of medicines. We looked in the medicine lockers for two people in the hospice. For both people we saw that staff were administering medicines which were brought into the hospice having being dispensed for other people. We also saw one medicine in the stock cupboard that was the patient's own medicine. This meant that staff could not be sure this medicine was safe to administer

Medicines were being kept securely and only accessible to staff authorised to handle medicines. Medicines requiring cold storage were kept within a refrigerator in the treatment room and the temperature of the refrigerator was monitored. However, the refrigerator's maximum temperature had been recorded as exceeding the recommended range for over a month without any action being taken. This meant the nurses could not be sure the medicines kept in the fridge were fit for use.

Medicines, including controlled drugs which require extra checks and special storage arrangements because of their potential for misuse, were stored securely and monitored regularly. Nurses completed weekly audits of controlled drugs but the audit was not effective, an audit completed two days before our visit had not identified a discrepancy in the stock which we found during the inspection.

Medicine errors were recorded on a monitoring system. Good records were kept of the actual incident; however we could not see evidence of the actions put in place to prevent them from re-occurring. All the staff members we spoke with were aware of how to report any medicines incidents.

Where required a range of risk assessments had been carried out to help keep people, staff and the premises safe. Risk assessments gave details of potential hazards, who was at risk and the control measures required to reduce the risk. Risk assessments covered health and safety related matters such as fire safety. As well as risk assessments, the provider completed a range of health and safety checks including checks of emergency lighting and fire, gas, electrical and water safety. The provider's procedures for dealing with unforeseen emergencies were under review at the time of this inspection.

Staff told us they felt the hospice was a safe place for people. One staff member said, "I am happy with the support, we are supported well." Another staff member commented, "I definitely think it is safe."

Once again staff showed a good understanding of safeguarding. One safeguarding concern had been identified since the last inspection. This had been fully investigated and resolved in line with the agreed procedures including referring to the local authority safeguarding team.

Staff also had a good understanding of the provider's whistleblowing procedure and knew how to raise concerns. One staff member told us they would have no hesitation in using the procedure if needed. They said, "You would have to do the right thing."

On admission a range of assessments had been completed to help identify and mitigate the impact of any potential risks to people's safety. People's care records contained assessments, using nationally recognised screening tools, relating to skin damage and nutrition. Other assessments were carried out covering areas such as moving and handling, falls and the use of bed rails. These had been completed accurately and clearly identified the measures in place to keep people safe.

Staffing levels were sufficient to meet people's needs in a timely manner. When we inspected there were four in-patients. We observed there was a high visible presence of medical, nursing and support staff on the in-patient unit when we visited. Staffing levels were two qualified nurses and two healthcare assistants plus the medical team. This meant, if needed, staff could respond quickly to people's changing needs. One person commented, "They come quickly, it doesn't take them long." Another person told us, "If I press the buzzer they are here quickly."

Staff members also confirmed staffing levels were good. One staff member commented, "[Medical staff] is well covered. Nursing staff is at the right level for patients." Another staff member said, "We have the right skill mix, it is fine." A third staff member commented, "Staffing is very good. We are all very good at picking up extra shifts."

The provider had effective systems in place to ensure new staff were recruited safely. For example, a range of pre-employment checks had been carried out to confirm new staff were suitable to work at the hospice. This included requesting and receiving references and checks with the Disclosure and Barring Service (DBS). DBS checks help employers make safer recruitment decisions as they are used to complete a criminal record and barring check on individuals who intend to work with children and vulnerable adults. We found evidence of a thorough interview and selection procedure having been followed such as application forms and interview records.

We viewed records which confirmed incidents and accidents were logged, investigated and action taken as

required to keep people safe. The registered manager completed a quarterly analysis of all incidents and accidents to ensure the correct action had been taken and to look for any trends and patterns. Incidents and accidents were classified according to type which was also used as a way of identifying patterns. For example, during the period 1 October 2017 to 31 December 2017 there had been eight accidents involving patients, four medicines incidents and one incident involving equipment. The analysis went on to consider each incident in isolation looking at the action staff took and completing a risk assessment.

Good

Is the service effective?

Our findings

When we last inspected the hospice the provider lacked a structured approach to supporting staff. Since this inspection the provider had made progress towards implementing a new support system for staff. For example, the new approach to be adopted had been documented into an agreed policy. An implementation plan was in place to be rolled out from April 2018 which included setting personal objectives for the year with progress to be monitored through one to one supervisions and appraisals. This meant there was a clear plan and structure in place to provide staff with the support they needed.

Staff told us they were well supported and received the training they needed. The provider was also pro-active about staff completing academic qualifications for both their personal development and to improve the care people received. Staff told us about the support they had received. One staff member commented, "Training is really good here. I am halfway through a diploma." Another staff member told us, "Staff go on training, we have recently done a dementia course so we are better equipped (to care for people living with dementia). I have asked to go on the next level. They [management] said yes no problem." A third staff member said, "We have great support and clinical supervision." A fourth staff member commented, "Support is really good. There are people you can go to in times of need."

Staff were also attending reflective practice sessions in order to learn from situations which had occurred in the hospice. Notes were available from these sessions to show evidence of the actions taken forward from the session. The provider's expectation was that each staff member should attend at least four sessions each year.

Essential training for all staff included fire safety, safeguarding adults, moving and handling and first aid. Records showed essential training was up-to-date for all staff at the time of this inspection. Some nurses were link nurses and specialised in certain areas such as dementia, blood transfusion and pain management. The role of the link nurse was to attend events and training and share their knowledge across the staff team to improve people's care.

Since our last inspection guidance and support had been implemented for qualified nurses to complete their revalidation. One nurse told us, "I was very well supported through revalidation. [Senior staff member] was very helpful. I can approach [hospice physicians] for help with clinical skills."

People's needs had been fully assessed on admission to the hospice. Care records contained a holistic assessment for each person. This evidenced people had been fully involved in the assessment including recording the person's understanding as to the reason for their admission and what their expectations were from their stay. For example, for one person this was to improve their own management of their symptoms and to get back home as quickly as possible.

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.

People can only be deprived of their liberty so that they can 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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. People staying in the in-patient unit were not being deprived of their liberty when we inspected the hospice and were able to consent to their admission to the hospice. We viewed care records for patients previously admitted to the hospice. These evidenced the provider was following the requirements of the MCA. For example, DoLS authorisations had been requested where people lacked the capacity to consent to their admission to the hospice. We also saw examples of MCA assessments and best interest decisions for a range of decision such as in relation to various treatment options, do not attempt cardio-pulmonary resuscitation (DNACPR) and people's preferred place of dying. Records confirmed these decisions had been reached in consultation with clinicians and relatives.

People received the support they needed to meet their nutritional needs. Where people had specialist requirements around feeding, specific care plans were in place to support staff on how to manage these needs. For example, for one person with a naso-gastric feed, their care plan described how the person should be positioned and the checks required to ensure they received their care safely. Accurate supplementary records were also available to show the required checks had been completed. The local health trust still provided meals into the hospice daily which included catering for special dietary requirements or cultural needs. People we spoke with told us the meals weren't always the best. However, the provider maintained its own stock of food supplies so that alternatives could be offered to people if needed.

Since our last inspection changes had been made to the medical team within the hospice. There was a full complement of hospice physicians available to treat and care for people. People told us they saw the medical team on a regular basis. One person said, "I see the doctor once a day. They always explain what they are doing and why." Another person commented, "I see the doctors pretty regularly, they are great." The provider's in-house physiotherapist offered a range of support options for people such as various therapies; stretching and strength programmes; balance and falls management; and fatigue management. The physiotherapist had completed 'train the trainer' training for moving and handling so that this training could be completed in-house from April 2018.

Good

Is the service caring?

Our findings

As with our last inspection we found the provider continued to provide good care. People we spoke with told us they were happy with the care they received at the hospice. One person commented, "This is a good hospice. It is nice and peaceful. I am happy with the care, I like it here"; and, "The staff are great, they are all good". Another person told us, "I get good care from the staff. They are very friendly, very helpful. It has all been good."

The hospice received a high number of compliments and thank you cards from people and their relatives. We viewed a sample of these which gave high praise about the care provided and the approach of the staff team. People had praised the hospice staff for their 'professionalism'; 'patience'; 'compassion'; 'care' and 'love'. Staff had been described as 'wonderful, lovely people' and 'angels.' One relative described how staying at the hospice had lifted their relative's spirits and had encouraged them to eat better.

We observed throughout our inspection that interactions between people and staff were always professional, polite and respectful. Staff knocked on doors before entering people's rooms and asked for permission before providing any care. People confirmed staff treated them with dignity and respect. Staff described some of the practical steps they adopted to maintain privacy and dignity. For example, promoting independence as much as possible, explaining what was happening and keeping people covered as much as possible. One staff member commented, "Privacy and dignity is most important for people. We try and maintain dignity as much as possible."

Staff described how they aimed to make people's stay a positive experience as much as possible. One staff member commented, "We try to make people feel it is not the end of the line, make people feel there is hope. It is a welcoming place. We make it as lovely as we can for the patient, we make it as nice as we can for them." Another staff member told us their aim for people was "To take stress away, be comforted by people [staff] who care."

There were opportunities for people to access emotional and spiritual support through the hospice's chaplaincy service. The chaplaincy team organised events for people to remember loved ones such as remembrance services and an annual 'Light up a Life' service. The hospice also offered a range of complementary therapies such as massage, aromatherapy and reflexology.

Care records showed that relatives had been involved in discussions about their relative's funeral arrangements after their death. This included talking about the wishes people had expressed when they were admitted to the hospice. We also noted discussions had taken place with relatives about the bereavement support available and advice about the grieving process. A bereavement counselling service was available which was run by a Bereavement Co-ordinator and supported by a team of volunteers who were either qualified counsellors or working towards a qualification. The service was confidential and available to people at the hospice as well as other locations. A bereaved relatives' satisfaction survey was being completed. The provider had not yet received the results from the survey.

Where required, people were given advice and supported to access advocacy services for independent advice. For example, one person had contacted an advocate to assist with decisions relating to their accommodation options when they were discharged from the hospice.

Good

Is the service responsive?

Our findings

We reported following our last inspection that care plans lacked personalisation. In particular, care plans were generic documents with a space to personalise the plan to the individual needs and preferences of each person. We found during this inspection generic care plans were still being used. Care plans tended to only have the person's name handwritten onto a standardised document with often no other information recorded about how the person wanted their care to be provided. We noted the provider had identified plans in their action plan to introduce personalised care planning. This was work was still on-going at the time of this inspection.

We found other care records such as daily progress reports were more personalised and included the views of people about how their care was being provided.

The format for care planning consisted of ten core care plans covering a range of care needs including assistance with personal care, stoma care, assistance with oral care, assistance with pressure care, communication and psychological support. Each plan had a generic goal for each care need and a generic action plan with bullet points. The plan had spaces for staff to handwrite the person's name into the plan and a space to record any individual care requirements people had. Additional care plans were available depending on people's needs such as for physical pain and nausea. As with our last inspection people did not have specific advance care plans in place. However, we did see evidence of people's wishes having been discussed throughout their stay at the hospice. For example, records showed these had been discussed on admission, at weekly multi-disciplinary team (MDT) meetings and when people were discharged.

We recommend as part of the current plans to change the format used for care planning, the provider researches best practice in person-centred care planning and updates its practice accordingly.

We attended the weekly MDT meeting on the first day of our inspection. The MDT included a detailed discussion with a range of professionals about each person's needs and an update on how their care and treatment was progressing. Notes from the MDT meetings were available to view in each person's care records.

As with our last inspection we saw medical staff monitored and managed people's pain effectively. We saw people were involved in measuring their pain levels using a specific pain management tool. This was reviewed at least weekly including reviewing treatment provided and whether this had helped.

The services available in the day hospice had been reviewed and updated to provide a structured programme called the "Living Better" programme. This was a six week programme focussed around helping people gain better control of their health and take ownership for their quality of life. Sessions attended during the programme included mindfulness, nutrition, exercise, sleep, relaxation, finances, complementary therapies and home support. The first session of the programme was to be held the week of our inspection.

People gave us positive feedback about their experience of the hospice and their care. One person said, "I have no complaints." There was a complaints procedure in place should people or others want to make a complaint about the hospice. There had been one complaint received since the last inspection. We saw this had been fully investigated and appropriate action taken to address the concerns including using the provider's disciplinary procedures.

Requires Improvement

Is the service well-led?

Our findings

When we last inspected the hospice we found the provider had breached the regulation relating to good governance. In particular some policies and procedures were overdue for review, such as the policy relating to the 'care of the dying person'. The provider could not be assured they were obtaining all their medicines in accordance with current legislation and best practice. We found some records were not always accurate and up-to-date particularly about pain management. People did not have care plans which detailed their preferences for their future care needs or advance care planning in line with National Institute of Clinical Excellence (NICE) guidance. Opportunities for communicating with staff were limited as team meetings were infrequent. The provider's approach to quality assurance was inconsistent and ineffective in identifying issues or concerns. Regular audits were not carried out across some clinical areas such as including checks of medicines.

We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. We found the provider had only completed one full medication audit and one audit of medication charts since our last visit in July 2016. The registered manager told us that whilst there was a new policy in place for the ordering and storage of medicines other related policies mentioned in this document were out-of-date and currently under review.

The provider could not be assured that they were obtaining all their medicines in accordance with current legislation and best practice. This was identified at our last inspection in July 2016 and the hospice had a plan in place to change supplier before the end of March 2018.

The provider had totally restructured the quality assurance system in operation at the hospice. A comprehensive clinical audit programme had been developed to be rolled out from April 2018. This covered various elements of people's care including treatment, medicines management, end of life and infection control. We were unable to establish how effective this programme would be as it had not been fully implemented when we inspected. The previous risk register for the hospice was also being restructured to make it more effective.

The provider had an overarching action plan in place to ensure compliance following our last inspection and to look further ahead towards becoming an outstanding hospice. We saw the provider had made significant progress towards completing the action plan. We also saw some areas still required further improvement, namely completing a review of medicines management processes, implementing individualised care plans, completing the review of policies and procedures and implementing a regular audit programme.

The provider had a registered manager who had been registered since 2010. They had been proactive in submitting statutory notifications to the Care Quality Commission in line with legal requirements. Staff members described the registered manager as supportive and approachable. One staff member told us, "It is well-led, we have an open door policy. [Registered manager] is very approachable. She is always there for you." Another staff member commented, "[Registered manager] is very approachable and [clinical lead]."

There was a positive and welcoming atmosphere when we visited the hospice. We found staff to be motivated and enthusiastic to do their best for people. One staff member described the hospice as "very friendly and very welcoming". Another staff member told us the whole staff team aimed to "go above and beyond" to meet people's individual needs. A third staff member commented, "The atmosphere is calm. Staff have a good relationship, we can have a really good day. The patients enjoy laughing."

Opportunities for staff to shape the future direction of the hospice and to provide feedback and suggestions had improved since our last inspection. One staff member told us, "We are involved in things now. We can be involved in developing policies if we want. We are asked if we want to be involved in staff forums. We have team building, staff meetings, a journal club meeting with speakers on subjects of interest." Minutes were available to show a range of meetings were taking place including team meetings, doctors meetings and management team meetings.

The hospice had a clear and transparent organisational structure with accountability and oversight sitting with the board of trustees. Since our last inspection the hospice had a new chief executive. We found them to be passionate and committed to their role and to improving and developing the services offered at the hospice. Staff also commented on the chief executive's management style and approach. One staff member told us, "[Chief executive] is fab. I would definitely talk to them. She often pops over even on a weekend. I have worked with her on the unit."

The chief executive told us that following her appointment a fundamental review of governance had been completed and that currently governance sat with the board. Development and training opportunities had been provided for board members including a skills audit assessment to identify any unmet skills requirements. The provider had re-launched the Clinical Governance Committee in December 2017 and the Finance Committee in January 2018. The remaining committees were to be re-established in April 2018.

The provider had redeveloped its five year strategy from 2018 and the draft version was available to view during our inspection. The document clearly articulated the provider's vison to become a lead provider of high quality and personalised care and the values underpinning the care provided at the hospice. These were based around: integrity; professionalism; compassion and being people-focused. The strategy identified a number of aims and what was required to achieve them. For instance, joint working with others, supporting diversity and exploring barriers to widen access to the care provided at the hospice.

There were opportunities available for people to give feedback about their care and views about other services provided at the hospice. Feedback we viewed was overwhelmingly positive with the 48 people and relatives completing a survey between October and December 2017 stating they were either 'likely' or 'very likely' to use the hospice again. We noted staff had been described as 'very good'; 'very understanding'; 'always helpful'; and 'wonderful'. The care provided at the hospice was 'excellent'; 'good' and 'second to none'.