Care Quality Commission

Isabel Hospice Limited

Isabel Hospice

Inspection report

Isabel Hospice, Rear of QE2 Hospital, Howlands,
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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 Care Quality Commission (CQC) which looks at the overall quality of the service.

This was an unannounced inspection. This meant the provider did not know we were visiting. At our previous inspection on 17 May 2014 the provider was found to have met the requirements of our Regulations.

Isabel Hospice provides an inpatient hospice service for symptom control and specialist palliative care, and a community service for people moving towards the end of their lives.

At the time of our inspection a registered manager was employed at the service. 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.

People and their relatives told us they were happy with the services provided by the hospice. They felt the staff understood their needs and they felt safe. The service

Summary of findings

only commenced care for people if it was safely able to meet their needs. People's wishes and preferences were taken into account and recorded in care plans. Risk management procedures were in place to ensure people's health risks were identified and plans were in place to manage those risks.

Staff demonstrated a good understanding of the needs of people with an end of life illness. Staff had received good training and support to meet people's needs.

The service worked well with other health and social care providers to ensure people's needs were met.

There were appropriate policies and procedures in place to support people should they ever have a need to complain or raise concerns. When concerns had been raised, they had been dealt with effectively.

There were systems in place to assess and monitor the quality of support provided for people.

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?
The service is safe.

People told us they felt staff understood their needs and they felt safe.

Staff were recruited only when all checks necessary to support the safety of people had been completed.

Staff understood safeguarding procedures and knew how to alert the relevant people if there were safeguarding concerns.

Good

Is the service effective?
The service is effective.

Staff had received training and on-going support to help them provide good quality care.

The provider worked well with other health and social care professionals to meet the needs of people they supported.

Good

Is the service caring?
The service is caring.

People told us staff were caring and kind.

People were actively involved in the decisions about their care and treatment.

We observed people being treated with dignity and respect at all times.

Good

Is the service responsive?
The service is responsive.

People had their individual needs regularly assessed and consistently met.

Management listened and acted on the views and opinions of people who used the service.

People were not always supported to follow their interests and take part in social activities if they were unable to leave their rooms.

Good

Is the service well-led?
The service is well-led

The registered manager and board of directors provided good support to the staff team. All staff were clear about their roles. They told us there was an open culture at the hospice.

There were appropriate arrangements in place to assess and monitor the quality of the service provided.

Good

Isabel Hospice

Detailed findings

Background to this inspection

The inspection team consisted of an inspector and a specialist advisor. The specialist advisor was a registered nurse who had experience of working in hospital and community settings.

Prior to our inspection we reviewed the provider's information return (PIR). This is information we asked the provider to send to us to show what they are doing well and the improvements they planned to make in the service. We also reviewed information we held about the service.

This included notifications. A notification is information about important events which the provider is required to send us by law. No concerns had been shared from the local authority.

During our inspection we spoke with five people who used the day service and three people's relatives. We spoke with the registered manager and seven members of staff and three volunteers. We also spoke with professionals who visited the service.

We reviewed four people's care records. We looked at staff records to determine staff recruitment, training, supervision and appraisal, quality assurance records, and arrangements for managing complaints.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe at Isabel Hospice. They told us the staff treated them well and with kindness and our observations confirmed this. One person said, "Very caring at all times, I am as safe as safe can be."

Staff told us that they understood what they needed to do if they had concerns a person was being abused. We saw staff had received training in safeguarding people and knew who they needed to report any safeguarding concerns to.

People's care records demonstrated the provider had assessed the risks relating to people's care and treatment. For example, a record we looked at in the inpatient unit showed skin, pain and nutritional assessments had been carried out and were accompanied by appropriate plans and guidance for staff. Staff told us that they had good communication methods to share information in relation to people's risks through handover meetings and feedback from people's daily reviews.

We found that people had agreed to their treatment and their capacity to make decisions had been assessed. We spoke with volunteers, nurses and doctors who described to us the approach they took when assessing people's mental capacity. They were able to tell us how and when they carried out best interest decisions, and the procedures followed when they needed to support people to make decisions in relation to resuscitation. This meant that people's consent to care and support had been obtained properly in line with the MCA 2005.

People told us and we observed there were enough staff to support people's care and treatment in a timely manner. The hospice had a waiting list for admission and we saw that staff managed the waiting list and admittance according to staffing levels and the impact of people's needs. At the time of our inspection there was one person who had been referred to the hospice, however there was no staffing capacity to take them. The community team had agreed to support the person until there was the capacity in the inpatient unit to able to do so. This person's needs were reviewed daily with updates between the hospice at home team and the hospice to ensure the person received safe care that was planned and delivered in a way to meet their needs. The Hospice's decision to wait before taking in another person was taken to ensure they were able to care for the people currently using the service to ensure care is provided by a sufficient number of staff.

Staff told us that they were required to provide employment history and references as part of the recruitment process. We looked at recruitment records and saw that all the required recruitment checks to support the safety of people using the service had been carried out. For example, criminal record and employers reference checks were carried out and an offer of employment was made only when the responses to the checks made were satisfactory.

Medicines were safely ordered, stored and disposed of and administered safely. During people's daily reviews by the medical team, people's medicines were reviewed to ensure they were effective for managing their current symptoms. We observed one person who was prescribed additional medicines as they were assessed as requiring them on the day of our inspection. We saw staff ordered the medicine as required, collected this swiftly from the pharmacy and booked it into the person's own stock. They noted the prescribing regime and then administered the medicine to the person.

People's allergies were clearly recorded, and records we looked at showed people received their medicines as they needed them. For medicines that are given as needed (PRN) for symptoms such as pain, doctors had written clear instructions on how and when these medicines are to be given. Staff told us that they discussed various medicines and their effects at team meetings. For example they discussed new medicines that were available and the reclassification of medicines so they were able to manage them appropriately.

Good

Is the service effective?

Our findings

People told us they felt supported and were cared for well by staff. One person's relative told us, "Things came as quite a shock and I didn't understand everything that was happening but the doctors and staff have been amazingly patient. They have made sure I understand all the options before agreeing to something for [relatives] care."

We were told that people were booked in for the day they were due to attend the hospice. Prior to people arriving, staff held a briefing meeting to discuss the person's immediate health needs. This meant the staff were aware of people's dependencies and what their needs were. We spoke with staff who were supporting a person who had been recently admitted. All staff we spoke with were aware of the person's care needs including end of life arrangements. We confirmed this by speaking with the person's relative and reviewing their care records.

Staff told us they felt well supported. They told us that there was a range of meetings they attended to discuss people's needs. We saw from records that staff attended multi-disciplinary meetings to discuss people's progress, discharge, and end of life arrangements. When a person was being admitted from their home, then a member of the community team attended prior to their admittance. This ensured that people were aware of the needs of people both prior to coming to the hospice or whilst they were there. Staff told us this benefitted them hugely to know how to provide a good level of care.

Staff told us clinical supervision was in place for clinical staff where matters could be discussed with a supervising practitioner. Staff told us this helped as they were able to get specialist support when required. Staff told us the daily meetings gave them sufficient opportunity to discuss people's needs and their own. We also saw that staff were additionally provided with frequent supervision to discuss and review their development and identify additional training opportunities. Staff had received specific training to support them with their work. For example staff had been trained in end of life care, advance care planning, bereavement, moving and handling, and infection control.

People told us they enjoyed the food provided to them at the hospice. We observed the lunchtime meal and saw that people were offered a range of healthy food options. Food served on the day looked appetising and people were encouraged to have a meal by the staff and volunteers. Where people required assistance with eating, staff spent sufficient time to ensure they ate enough food. Where people found it difficult to eat due to loss of appetite, we saw staff encouraged people to eat an alternative meal or suggested an alternative they could try to eat later. One person was observed to ask for a pudding as their main meal. We saw the staff member attempt to persuade them to eat a main meal however they declined. The person was heard to say, "It may be the last meal I will eat, and if so I want to enjoy it." They were given the pudding to eat. A second person told us, "Even the food that is blended tastes good."

Kitchen staff we spoke with told us in detail about the individual requirements of people's diets. For example the kitchen volunteer told us which people needed specially prepared food and which foods people preferred. When we spoke with one person they confirmed this by saying, "They know me and what I like." Where people required fortification due to them being at risk of losing weight, supplements were offered and foods were fortified. People were able to bring their own snacks and drinks into the hospice with them; however we also saw people were frequently being offered refreshments throughout the day by staff and volunteers.

People were supported to maintain good health and to have access to health care services and receive on-going health care support. Each clinic was led by doctors and qualified nurses who were supported by a range of healthcare professionals and volunteers. All staff working at the hospice demonstrated a good knowledge of the people's conditions and the treatments available to them. Staff spent time to help people and their relatives understand their conditions and how they can access support groups run by both Isabel Hospice and external groups.

The staff we spoke to and visiting professionals told us they worked closely with other organisations and professionals. They told us hospice staff attended a multi-disciplinary meeting each week which included the consultant in palliative medicine, the community service and health professionals required. This meant all services worked closely together to provide effective support to people with life limiting illnesses.

People who used the community service told us they were involved in the development of their care plan. Staff from

Good

Is the service effective?

the hospice at home team visited patients on the hospital inpatient unit prior to discharge to introduce themselves and discuss their needs. This helped to ensure that people were provided with a consistent package of care.

We found that people were not always able to pass away at their place of their choice. The hospice had identified people whose condition was deteriorating and for whom home had been identified by the person as the preferred place for care. Staff would attempt to fast track a person to the local nursing teams to ensure a rapid discharge so that they could have their preference realised and be at home to die. However we found examples where the hospice had identified people and referred them to the NHS Continuing Care Team for fast track assessment; however they were on occasion not assessed in sufficient time. This led to the hospice at home team providing care they were not funded for, to ensure people in the majority of cases were able to die at their preferred place of care. The manager and provider are aware of this issue, and are working with the local health commissioning team to find a solution. This meant that the hospice sometimes undertook the responsibilities of their partners to ensure people and their relative's preferences were met.

Good

Is the service caring?

Our findings

People we spoke with were very positive about the care they received. One person we spoke with told us, "Naturally I would choose to never have to be here, but as I do, I can't think of a better place to be when I pass on. The staff can never do enough to make me any more comfortable, and they are the most caring bunch I have met doing a really tough job." One relative told us, "After [relative] was supported by Isabel, I came back to volunteer myself to help others like the staff helped me. It is an amazing place full of warmth, kindness and compassion."

We spent time observing and speaking with people who used the hospice service. We saw friendly and positive relationships had developed between staff and people. Relatives told us they enjoyed coming to the service. They told us the staff were, "Heroes" and the hospice was, "A calm, peaceful and happy place that was a testament to the professionalism of the staff".

We observed staff being responsive to people and their family members when they needed support. We observed positive, supportive and compassionate interactions where people were anxious or distressed. One person's relative visited whilst we were present and was upset at a recent loss. We saw that the staff member very quickly and with minimal fuss supported the person to a quiet area and took the time needed to settle them.

We observed that care was delivered in an individual manner and centred on each person. Staff had a good understanding of people's needs and provided care with kindness and compassion. They understood how to provide care with respect and ensuring people's dignity was maintained. For example, at the hospice inpatient unit we observed one person becoming anxious during meal time. We saw a member of staff was close by and quietly and discreetly indicated to the person that they were there if help was needed to leave the room. The person accepted the help offered. The member of staff told us they knew the person might get anxious and had deliberately positioned themselves close by to be there for support if required.

We saw people were actively involved in decisions about their end of life care. Following best practice the hospice had ceased using a standard end of life care plan (Liverpool Pathway) and had adopted an individualised approach to planning end of life care. We saw staff liaising with a nursing home to arrange a discharge as the person wished to be closer to their loved ones. The assessments carried out for discharge were thorough and took account of the wishes of the persons relatives and loved ones. When people's end of life care plans were developed, this was discussed among the clinical team and where appropriate sought input from community teams such as care agencies.

The staff had recently developed a patient support program which provided people with mutual support around issues such as loss, bereavement and anxiety. When people had passed away Isabel Hospice provided bereavement and counselling service for people to attend to receive support. People were encouraged to continue to use the support of the hospice for as long as they required. One person we spoke with told us, "It was a really helpful at a time when I felt alone and isolated. To be with others who had experienced the same really helped me." People's religious and spiritual needs were supported at the hospice. We saw a chaplain regularly visited people who requested this, and arrangements could be made for other faiths where required.

Good

Is the service responsive?

Our findings

All people who used the services offered at Isabel Hospice told us they received care and treatment which met their individual needs. People told us they felt staff listened to them and their treatment plans were tailor made to them. One person told us, "I have been here for symptom control and pain management and have felt very much in control. The Doctors and nurses listen and tailor what I need to what I want." A second person told us, "No matter what worries I have, they listen to me and make it better." One person's relative we spoke with told us, "I have phoned day and night to see how [relative] is doing. When I phone the staff listen to my concerns and always find the right staff with the right answer, I am very happy with the care."

We looked at care records of people who used the hospice. These demonstrated to us that people's needs had been thoroughly assessed by a team of professionals and the views of the person had been acted upon. For example, one person had been assessed as needing more psychological support and had been referred and had an appointment to see a psychologist.

We saw people had their care and treatment needs reviewed at each visit. In the inpatient setting this was done on a daily basis through doctors carrying out a ward round. Where people's needs had changed, for example, with pain management, Doctor's swiftly reviewed the person's symptoms and provided appropriate pain relief, and referral for specialist services if required.

One person told us, "We don't use the big room, the television is never on," and another said "It's boring most of the time." People observed in the lounge area had little to interest them on the day of the inspection. However we did see the hospice had provided a range of activities that included complimentary therapies, hairdressing, arts and crafts and a bedroom volunteer scheme. This enabled the volunteer staff to spend one on one time with people in their rooms who were unable to get out of bed. One person told us they could only see outlines and mentioned that they had been in the hospice for several weeks but had been bored. They said, "I listen to quiz programmes on the television at home but here it is too much trouble." The person did however have their own talking books which they very much enjoyed with support from staff. We spoke to the registered manager who took appropriate action and subsequently provided us with a report which had addressed these issues.

A complaints policy was in place and copies were provided to people and their relatives. One staff member we spoke with told us, "If there is a mistake or a concern the management always do a root cause analysis, to ensure feedback and learning." Records of complaints we looked at showed us the service responded quickly to complaints raised. People told us they were aware of how to make a complaint and who to raise their concerns with. They said that they felt their concerns would be taken seriously and acted upon. Where a complaint was raised, this was passed to the manager and thoroughly investigated. A response letter was sent and a meeting was arranged to discuss the concern and outcome. Where people were not satisfied with their response they was an escalation system in place for review by the Board of Directors and then external agencies.

Good

Is the service responsive?

Our findings

Staff we spoke with told us that the manager was approachable, and they felt they could take their concerns to them and be listened to.

The service had a registered manager in post who was responsible for ensuring the service met its legal requirements. The registered manager was supported by a board of directors which met

regularly to review the quality of service provided to people. The minutes of the meetings demonstrated the board considered a wide range of issues such as infection control, clinical incidents, discharge, training, compliments and complaints and risk management. The board and senior managers took responsibility for things that happened in the service, and responded to these appropriately. The manager ensured that learning and key messages were given to staff.

Staff we spoke with felt fully supported by the manager and the board of directors. They told us the manager reported to them any issues raised at more senior meetings and they felt fully briefed about the management of the organisation. Staff we spoke with told us the Board of Trustees and management encouraged an open culture where practise issues and decisions could be challenged freely. One staff member told us, "It is a fair culture not blame culture, which means we look at what happened and learn from it, and then support each other to improve. I feel comfortable to approach the manager if I may have done something wrong."

We looked at incident and accidents which had occurred at the service. There had been a higher than average number of medication errors recorded over the previous twelve months. However the manager had carried out a full investigation into this, and found that the spike in reporting was due to staff feeling able to report mistakes. In recent weeks the management team had worked with staff to develop a culture within the hospice that sought to learn from incidents, and provide retraining where appropriate. When we looked at the issues highlighted, we found that many did not require notifying, yet all had been reviewed and discussed. Where an error had occurred that may have caused harm, staff were spoken with and provided with the necessary training and support. Staff we spoke with confirmed the culture of the hospice was open and they were encouraged to challenge practise. Minutes of team meetings we looked at demonstrated that staff were encouraged to raise concerns and challenge practise where the felt it was appropriate.

The hospice had a clinical governance group which is a staff group that helps to sustain and improve standards of clinical care. We looked at the minutes of these meetings and they showed the service was striving to provide a quality service. Areas covered in the quality audit and governance meetings included organisational risk and planning, contingency planning and clinical concerns arising. This meant that the service managed a proactive approach to quality and all staff were aware of potential risks that may compromise quality.

We reviewed samples of quality surveys that had been sent to people and their relatives. Surveys were completed for various areas of the service that Isabel Hospice provided. For example the inpatient unit and bereavement service. The management team analysed the results of these and presented a report to the board of directors. Where necessary actions were developed to improve the service following feedback. Copies of the results were available to people to review. This meant that there was a formal approach to seek and act upon the views of people to improve the quality of service provided.

This section is primarily information for the provider

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

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