Care Quality Commission

Hospice of the Good Shepherd Ltd

Hospice of the Good Shepherd

Inspection report

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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

Summary of findings

Overall summary

We inspected this service on 6 and 7 June 2016 and we gave short notice to the registered provider prior to our visit. This was to ensure that key people were available during the inspection.

The Hospice of the Good Shepherd provides specialist palliative care to persons over the age of 18 years. It also provides respite care for people with complex nursing needs. There is an inpatient unit with 12 beds and a day care facility with 10 places. The Hospice provides specialist palliative care through a multi-skilled and qualified staff team. They are able to offer a range of medical treatment and complementary therapies to address symptoms, enhance quality and life and meet a patient's holistic needs which include physical, emotional, psychological, spiritual and social needs. Their end of life care provides support, dignity and comfort to those in the terminal stage of an illness. The hospice also provides complementary therapies and counselling services to families, though these services fall outside the regulatory framework of the Health and Social Care Act 2008. The service is situated in the suburbs of Chester, close to a range of local shops and other amenities. Car parking is available to the side and rear of the premises.

During the past year the hospice has provided 358 In-patient stays and had 360 day therapy attendances. There were also over 800 medical consultations in hospice out-patients and day therapy.

At the time of this inspection there were eight inpatients at the hospice.

The previous inspection was undertaken in January 2014 and the service had met the regulations in place at that time.

There was a registered manager in place at this service, who has been registered for two and a half years. 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.

We have made recommendations about the management of medicines because these were not always safe, although the management said they would follow this us this was the findings at the time of the inspection.

People told us that they received very good quality of care from all the staff at the hospice. People told us they staff were kind, patient and caring towards them and that they supported them to meet their physical, social and emotional needs. People described the culture of the service as positive and caring.

People told us they felt safe at the service with the staff team. Staff had been trained to recognise and report any signs of abuse. No safeguarding issues had arisen at the service since the last inspection.

Care plans were person-centred and kept up to date. End of life care was given in sensitive and appropriate

ways that acknowledged people's rights and preferences. The service promoted a "focus on living" approach to care which supported people and their families to enjoy the time they had together and enhance their feelings of well-being.

The staffing levels were good and sufficient staff were seen on the days the inspection took place. Staff were well trained and had access to a variety of training courses to enable them to develop their skills and knowledge base. Good support was given to staff by senior management and regular meetings and supervision sessions were undertaken.

Robust staff recruitment processes were in place which ensured that only staff who met the service's high specifications regarding experience and qualifications, character and caring abilities were employed. This included the recruitment of volunteers.

People told us the food was very good and that they had access to snacks and drinks whenever they wanted them. Care plans showed that a nutritious diet was encouraged.

The service worked closely with other professionals and agencies to ensure people's holistic needs were fully met. There was clear evidence of close and effective partnership working between the service, families, carers, and external professionals.

Regular checks were made regarding the safety of the building and equipment. Staff were given training in safe working practices and provided with any necessary personal protective equipment. The building was clean, hygienic and in a good state of repair.

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

The service was safe.

Medication management was not always safe and recommendations were made, although the management said they would follow it up.

Robust and safe recruitment practices were in place. Staff were trained and aware of how to protect people from abuse and harm. They knew how to report any concerns.

Risk assessments were centred around the individual and their specific needs. There was sufficient staff on duty to meet the needs of people safely.

Is the service effective?

Good

The service was effective.

Staff were trained appropriately and they had a good knowledge of how to support each person's specific needs.

People told us the food was very good and that they could have food and drinks whenever they wished.

The registered manager understood the principles of the Mental Capacity Act (MCA) 2005 and how to apply these. Staff had received training on the MCA 2005.

Is the service caring?

Good

The service was caring.

People's feedback about the caring approach of staff was extremely positive and was described as "Excellent". The service was very flexible and responded quickly to people's changing needs or wishes.

Staff showed kindness and knew when and how to convey empathy to people when they faced difficult situations.

Is the service responsive?

Good

The service was responsive.

People and their families were fully involved in assessing their needs and planning how their care should be given.

Staff delivered people's care in a person-centred way and encouraged them to make choices about their daily lives.

People told us they didn't have any complaints about the service. A Complaints policy and procedure was in place for people to use if they wished to make a complaint. No complaints had been received by the registered provider or CQC.

Is the service well-led?

Good

The service was well led.

There was a clear management structure and lines of accountability in place. People and staff told us the service was well managed.

Systems were in place to monitor the quality of the service provided.

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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.

We inspected the service on 6 and 7 June 2016. We gave short notice to the registered provider because we needed to be sure that key people would be available during our inspection visit. The inspection team consisted of an adult social care inspector and a pharmacist specialist advisor.

We spent time at the service looking at records. This included two people's care and support records, five staff and two volunteer recruitment files, policies and procedures and other records relating to the management of the service.

Before our inspection, we reviewed all the information we held about the service. This included looking at any safeguarding referrals received, whether any complaints had been made and any other information from members of the public. Before the inspection we looked at notifications we had received. A notification is information about important events which the service is required to tell us about by law.

We contacted the local authority safeguarding and contracts teams for their views on the service. They raised no concerns about this service.

On the days of our inspection we spoke with four people who used the service, one relative, two trustees, one volunteer, the registered manager and seven staff members.

Good

Is the service safe?

Our findings

People told us they felt safe at the hospice and that there was enough staff around to meet their needs. Comments included "The staff support me safely", "I feel safe here, very much so" and "I feel safe and secure here".

Staff told us about how people were kept safe and they were aware of how to raise concerns and felt confident that they could speak to the senior person on duty. One staff member told us "I have been involved with a safeguarding issue recently and it was handled well." Staff said they had received training in safeguarding adults and children and records seen confirmed this. The registered provider had safeguarding policies and procedures in place and a copy of the local authority's safeguarding policy was available to the staff team. A flow chart was in place to show what to do in the event of suspected abuse. Other policies staff had access to included whistle blowing and staff confirmed they were aware of these policies and procedures. They told us that the employee handbook also contained information on what they should do if they had any concerns.

People told us that they received their medicines when they needed them and that staff were responsive to their changing medication needs. The use of the automated MEDI 365 system helped staff manage medicines safely. MEDI 365 is an Automated Control System, which allowed staff to control, dispense and manage medication in the service. This helped assure accuracy, control and security. We were shown how the system operated in dispensing regular and controlled drugs to people. The staff member entered a login and this was followed by fingerprint recognition which helped to provide a secure login system.

We reviewed the medication process for three people. Medication Administration Records (MARs) were used well and further information was available within the MARs Folder. Separate charts were available for PRN (when required medication), ongoing standard medication, potential syringe driver set-up, and end of life (EOL) medication. A clear and safe process established which medication people required. Following a medication administration round a "Check my Charts" laminated card was placed in each person's folder. A different nurse would check that the administrations had been fully carried out and recorded.

A range of medication administration policies and procedures were being reviewed and were currently available in draft format. There was no policy, protocols or guidance for PRN administration of medication. Staff said they would use their clinical judgement in these cases. We discussed this with the medical director. They said there had been discussions in the multi-disciplinary team meetings as to whether the use of "Abby pain scales" to determine people's level of pain, should be implemented. A multi-disciplinary meeting is where relevant health and social care professionals meet to review and plan people's care and treatment. We recommend that a system should be implemented and extended to all PRN medications.

We noted that a handwritten original prescription for all Controlled Drugs (CDs) supplied was not sent to the Countess of Chester Hospital prior to the medication being received by the service. A copy of the prescription was faxed to the hospital and the drugs were dispensed on viewing this. This was not the correct procedure from the perspective of the pharmacy supply and a recommendation was made. This was

discussed with the registered manager and they agreed to remedy this. On the second day of inspection we saw that this process had been changed.

A Service Level Agreement (SLA) was in place with Countess of Chester Hospital (COCH). This detailed the supply arrangements of medication. This worked well and with the added support of clinical pharmacists, this gave the hospice an excellent professional backup. However, the current SLA had expired and needed to be renewed. The new version of the SLA needed to include changes to the CD requisition arrangements. It stated that pharmacist audit visits were two, three-hour visits a week however on discussion with the pharmacist they explained they visited for two hours twice a week. This was less than agreed in the SLA and the extra time would be of benefit to support the nursing team. There were no set time frames specified within the drug delivery arrangements. This worked well, however, if changes were made to the management at the COCH then the current good arrangements could change and this could impact on people's safety. A recommendation was made to ensure that the SLA is drawn up in line with the service's needs.

We looked at recruitment processes and reviewed five staff and two volunteer's recruitment files. These were well presented and information was easy to access. Staff and volunteers had completed an application form and attended an interview. References and a Disclosure and Barring Service (DBS) check had been undertaken to ensure staff and volunteers were suitable to work at the service. A DBS is undertaken to ensure that staff are suitable to work with people within this type of service. This meant that good recruitment processes were in place to ensure people were supported by suitable staff.

People told us there was always plenty of staff about and that call bells were answered quickly. Comments included "Yes there are always enough staff about" and "You get wonderful attention here". Staff rotas showed that nurses, care staff and ancillary staff were available as needed. During the inspection we saw plenty of staff available to support people's needs. Staffing levels were determined by the number of people who used the service and their needs and this was adjusted on a regular basis. However, regardless of how many patients were staying at the service there was a minimum of two registered nurses on duty.

During a tour of the building we found it was clean and free from offensive odours. Building work was in progress for the new day therapy unit and all appropriate safety checks had been carried out. People and visitors said the hospice was very clean. Comments included "It is very clean here", "There are no problems about cleanliness here" and "Staff work hard to keep the hospice clean". Staff told us they had training in infection control and records confirmed this. We noted that doors into the building were not locked, however, there was a volunteer or staff member on reception from 9am – 5pm daily. Outside these times the door was locked and access was gained via an intercom system. Comments from people and relatives showed they were requested to sign in on arrival at the service. They said they could visit whenever they wanted and stay as long as they wished.

Throughout the service, fittings and equipment were regularly checked and serviced. There was a system in place to identify any repairs needed and action was taken to remedy these in a timely manner. We saw that safety checks were in place for the gas and electrical systems and that the fire alarm and nurse call systems were regularly checked and serviced. This meant that good systems were in place to ensure that the service was safe and adequately maintained

Care records contained up-to-date risk assessments for areas such as pressure care, manual handling and pain management. We saw that risk assessments were up to date and reviewed every few days during each person's stay.

Good

Is the service effective?

Our findings

All the people we spoke with said the food was very good and that they could have drinks and snacks whenever they wanted. People said "The food is very good", "Drinks and snacks are always available" and "I get what I want when I want it". Jugs of water were provided to people in their rooms and were kept within reaching distance in case people became thirsty.

There was a four weekly menu in place which showed that choices were available at each mealtime. One staff member explained that if a person didn't want the menu on offer then other options such as omelettes, sandwiches or jacket potatoes were also available. The menu was varied and the chef visited each person twice a day to ask them about their preferred choice of meal. A detailed folder was available for staff which contained information on known allergens. Staff told us they referred to it when people asked for specific information about meals provided. This helped to ensure that appropriate information was available for people who used the service with regard to food allergies. A nutritional needs and preference sheet was completed with people who used the service and showed people's dietary needs or concerns and any further information staff may need. This document, a copy of which was displayed in the kitchen, helped staff offer suitable foods to meet people's dietary needs.

Daily temperature checks were undertaken and recorded on fridges, freezers and hot food prior to it being served. This meant that all foods were stored and served at appropriate temperatures to ensure that risks were minimised. The catering manager said they had worked for the service for over twenty years and enjoyed their job. They said the staff team was good and worked well together. They commented that people who stayed at the hospice needed good nourishment and that the hospice cared for people and supported their family and carers as well.

Staff told us about the training they received. They said they completed a days "mandatory training" each year and that the training was good. One person said the "Training is very good. We have a mandatory training day". Staff were asked to feedback after each session and comments included "Very information session", "A mindful session", "A very well delivered session" and "A good teacher with good interactive skills". Each staff member had a training log which detailed all training they had attended. All staff undertook a range of training in line with their role which included manual handling, fire safety, safeguarding for adults and children, Mental Capacity Act 2005 and infection control. Other training included food allergy, information governance, end of life care, dementia awareness, supporting family carers in palliative care and advanced communication skills. The nursing staff had also undertaken a wide range of specialist training to help maintain their continuous professional development. The registered manager explained that staff had the opportunity to discuss their work and training needs with a senior staff member and that these were also identified within annual appraisals. Records showed regular supervisions and appraisals had taken place.

Staff induction was tailored to roles, for example, nursing staff, nursing assistants, doctors and volunteers. The induction consisted on an introduction to the service and personnel, general employee related information, training and development, policies and procedures and other information relating to the staff

member's role. The induction was signed by a line manager on completion.

People told us that their pain control and physical symptoms were managed well by the staff team. They said "Staff are very attentive" and "Staff respond quickly when my pain increases". One person said "The social worker (at the hospice) gave very good and helpful advice" to them in regards to the support they might be entitled to. Another person said that the staff organised "Care at home" to support them when they returned home. They said that everything was organised for them and that it helped them not to worry when they returned home. A wide range of professionals were involved with supporting people which included doctors, nurses, physiotherapists, social workers and counsellors. This meant that people had access to a range of services which they could request the hospice staff to organise on their behalf.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA 2005. People who normally live in their own homes can only be deprived of their liberty through a Court of Protection order.

We checked whether the service was working within the principles of the MCA 2005, and whether any conditions or authorisations to deprive a person of their liberty were being met. The registered manager was aware of the principles of the Act and how to determine people's capacity. The registered provider had up to date policies and procedures in regard to the MCA 2005 and DoLS, Best Interests and Lasting Power of Attorney (LPA). LPA is where someone is appointed by the Court of Protection to make decisions on the person's behalf within specific areas of their life. Care records showed that people's mental capacity was considered. Daily notes recorded that care staff assessed people's capacity prior to carrying out care tasks, for example in one record it stated "Patient has full capacity for care decisions". Staff had received training in the MCA 2005, and were aware of their roles and responsibilities in regard to this.

Good

Is the service caring?

Our findings

People who used the service and relatives told use how they positively appreciated the service that was provided and the way in which it was delivered. All their comments were overwhelmingly positive. People told us that they were very pleased with their care. People commented "The staff are very good", "Staff are very attentive" and "The staff are caring and marvellous". Relatives commented "The staff are accessible and I can speak to them at any time" and "The staff are amazing in terms of care, support and friendship".

During discussions with the staff we asked them how they showed dignity and respect to people who used the service. They explained they would ensure that doors were closed before supporting someone with personal care tasks. They would know what people wanted as this was discussed in the handover sessions. We saw that staff knocked gently on bedroom doors and waited before entering. Bedroom doors were left open or closed at the person's request and staff regularly checked on people's well-being.

Staff said that information was available during handovers with regard to people's needs and care plans showed what support people needed. Staff said "We also interact with the person and ask them how they want to be supported" and "Care and support is person led and it's documented in the care records.

There was a homely feel at the service. There was a social atmosphere where people were encouraged to chat if they wished to and were listened to. Staff and volunteers smiled and engaged with people. They stopped and listened to people and responded to them with genuine warmth and friendliness. Staff approach was kind, patient and respectful. There was friendly and humorous banter between people and staff and people were addressed respectfully and by their preferred name.

People told us that they could get up and go to bed when they wanted to. One person said that they wanted to get out of bed and they were helped to sit in a recliner chair. They said "The chair is fully adjustable by myself so I can have it how I want". They also commented that you only have to say to one of the staff that you want to go to bed and someone comes to help you.

Relatives told us they were welcomed at the service at any time. Comments included "It feels like at home here" and "I am offered drinks and snacks". The registered manager said that visitors were welcome day and night and that sleeping facilities were provided, either within their relatives room or in a separate room if preferred.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Each person's wishes were at the centre of the service. A pain management programme was written for each person and symptom control and pain management was discussed with the individual prior to changes being made. The person was fully involved in the decision making process and their wishes were respected.

People had access to the spiritual care team who were available to help meet people's spiritual and religious needs. The aim of the team was to provide support and a listening ear to people. Within the care records there was evidence of people's engagement with the team, for example "[Name] had contact with

the Chaplain today". The quiet room was a place where people with different faiths could practice their particular beliefs. It also provided a place for quiet reflection for people with spiritual but not necessarily religious beliefs. There were resources from different faith traditions available within the room. A staff member explained that religious leaders from people's own faith could visit the service and minister to them as appropriate.

Staff were attentive to people's needs including their emotional needs. People commented "Staff are always available to talk about any worries I have" and "You have helped me come to terms with what is happening to me". Counselling therapy was offered and provided to people. This extended to relatives, young people and children. This often involved using creative activities such as drawing and painting to enable people to express their thoughts and feelings about what was happening to them and their relative. A range of leaflets were available to people to assist them in getting support such as counselling and bereavement support, including bereavement support for children. Staff told us that families and carers were encouraged were supported during their bereavement and counselling was also offered. People were encouraged to continue to visit the service and were personally invited back to the hospice for social events and the annual remembrance service.

Good

Is the service responsive?

Our findings

People and their relatives told us that the way staff responded to their needs was "Excellent" and "The staff are amazing here". They said that they were treated as an individual and that staff were "Very attentive" and "Very good indeed".

People who used the service and their relatives made a lot of positive comments about the care and support they received from staff at the service. They all expressed how responsive the staff had been to people's needs and they thanked them for all their support. Comments included "Thank you for the wonderful care you have provided", "Thank you for being so kind and caring", "[Name] was in a lot of pain and you helped to take that away as best you could" and a relative commented "It was very reassuring to be able to go home and leave [name] in your capable hands".

The Hospice of the Good Shepherd had a website which provided information about the service, the facilities and different types of support offered. When people accessed the service they were provided with information which provided further details of the type of care and support they could expect to receive.

People told us they could express their views and were involved in making decisions about all aspects of their care. They told us they felt listened to. We observed staff enquiring about people's comfort and welfare and responding promptly to people's request for any assistance. One staff member told us "We make the time to understand each person as an individual and what they want."

Prior to people entering the service, an initial assessment of their needs was completed and the outcome was used to plan people's care. The assessment took account of information such as people's previous and current medical history. It also included information about people's Next of Kin (NOK), details of other professional's involved and people's religious preferences. Care plans contained information on the management of pressure areas and in one example we saw this included the mattress type required and gave specific information on the location of skin issues. Daily notes showed that people had received pressure area care appropriate to their needs. Daily notes contained evidence that pain relief was given to people as required. People had received support each day with regard to nutrition, pain and mental capacity. For example "Patient has full capacity for care decisions" which was recorded on a regular basis in people's notes. Other records included dietary and fluid intake.

We looked at two people's care plans and associated documents which were all up to date. Care plans identified people's needs and how they should be met. This included information about personal care needs, moving and handling, management of pressure areas and pain management. Information around the support that people required was included in their care plans. For example "Requires the assistance of one" and "Encourage [name] to take more fluids". Care records were reviewed every few days which meant that staff had access to up to date information. Do Not Attempt Resuscitation (DNAR) authorisations were in place for some people. We noted that people and their families where appropriate had been involved in these authorisations. Staff knew who had a DNAR in place and where these were kept.

The hospice had systems in place to ensure they could respond to people's changing needs. These included daily admission meetings, weekly meetings for all sections of the hospice and weekly multi-disciplinary meetings. A multi-disciplinary meeting is where relevant health and social care professionals meet to review and plan people's care and treatment. This helped ensure the continuity of care for people moving between care settings. The staff told us there was a handover at the end of each shift. One staff member told us "Communication is key, how we care for people can make a difference. Anything that has changed no matter how small, we need to know these things."

People who used the service and relatives told us they didn't have any concerns or complaints about the service. A comments and complaints policy was displayed in the foyer and there were complaints forms available for people to complete should they wish to raise a concern or complaint. No complaints had been received by the registered manager in the last year, however the procedure for dealing with complaints aimed to address them in a timely manner to the satisfaction of the complainant.

Good

Is the service well-led?

Our findings

A registered manager was in post that had been registered with the Care Quality Commission (CQC) for two and a half years. The registered manager had worked for the hospice for twenty-six years in various roles and had a vast experience of caring for people within a hospice setting. The registered manager was supported by the registered provider, doctors, nurses, care workers, other professionals and volunteers.

The service governance structure included a board of trustees. We spoke with two of the trustees about the culture of the service. They told us about the work that had been undertaken at the service which included the work they had carried out to raise awareness of the hospice care. Their aim was to ensure care was provided in a personalised way that respected people's independence, privacy and dignity. During our visit we observed the registered manager and staff acted according to these values.

There was a clear management structure at the service. Staff were aware of the roles of the management team and told us the registered manager was approachable and had a regular presence within the hospice. Staff told us they had a commitment to providing a good quality service for people who they supported. This meant there was an open and positive culture within the service which focussed on people who used the service.

The registered manager was open and transparent. They regularly notified CQC as required by law of significant incidents and events that affected people or the running of the service. Notifications were sent shortly after the incidents occurred which meant that we had been notified in a timely manner.

The registered manager told us the use of volunteers played a major role in supporting the service. Volunteers worked directly within the service and also in the community, such as in the charity shops and other fund raising events to help raise funds for the service.

The registered provider had a business improvement plan in place. This covered care, fundraising, lottery applications, people, corporate services and communications. Some areas of improvement included development of the catering and housekeeping services. The implementation of an annual training plan and the new build at the hospice to incorporate a larger day therapy unit and four en-suite bedrooms was in progress.

Service user surveys were completed between July and December 2015 and an in depth analysis of the information had been completed and a "You said………were doing" document produced. People said that the hospice was very clean, they rated the food as very good and there were always enough staff available. Additional comments people made in surveys included "I had enough privacy and staff were available to talk about my worries and fears", "I was involved in all aspects of my care and discharge", "Doctors and nurses worked excellently together", "Staff are absolutely brilliant" and "The nurses at the hospice are amazing".

A range of audits were completed by the staff team and registered manager. These included accidents and

incidents, medication, including controlled drugs and drug related incidents. Also non-drug related incidents, falls, pressure sores, health and safety and information governance. This provided a comprehensive breakdown and recording of incidents. Members of the board of trustees also carry out audits with service users, families and carers, staff and general observations and management.