Care Quality Commission

Sue Ryder

Sue Ryder - St John's

Inspection report

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13 April 2016

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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

This inspection took place on 12 and 13 April 2016 and was unannounced.

Sue Ryder St John's is a hospice that also provides specialist outpatient treatments and remote, telephone advice services. Fifteen beds are provided in the accommodation facilities at Sue Ryder St John's. At the time of our inspection four people were using the in-patient facilities.

There was a registered manager in post. 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 felt safe. Staff had received training to enable them to recognise signs and symptoms of abuse and how to report them. People had risk assessments in place to enable them to be as safe and independent as they could be.

There were sufficient staff, with the correct skill mix, on duty to support people with their care and treatment needs. Effective recruitment processes were in place and followed by the provider.

Medicines were managed safely. The processes in place ensured that the administration and handling of medicines, including controlled medicines, was suitable for the people who used the service.

Staff received a comprehensive induction process and on-going training. They were well supported by the registered manager, director and the provider and had regular one to one time for supervisions. Staff had attended a variety of training to ensure they were able to provide care based on current practice when providing care and treatment for people.

Staff gained consent before supporting people or providing care and treatment. People were supported to make decisions about all aspects of their life; this was underpinned by the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff were knowledgeable of this guidance and correct processes were in place to protect people.

People were able to make choices about the food and drink they had, and staff gave support when required. specialist diets were catered for.

People were supported to access a variety of additional health professional when required. Alternative therapy was available including; aromatherapy, Indian head and Swedish massages, reflexology, reiki and aromatherapy.

There was an extensive support programme, manned 24 hours to provide a single point of contact for additional support. The service had a Black, Minority and Ethnic (BME) outreach worker who worked closely with the wider community.

Staff provided care and support in a caring and meaningful way. They knew the people who used the service well. People and relatives, where appropriate, were involved in the planning of their care and support. People's privacy and dignity was maintained at all times.

A complaints procedure was in place and accessible to all. People knew how to complain.

Effective quality monitoring systems were in place. A variety of audits were carried out and used to drive improvement.

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.

Staff were knowledgeable about protecting people from harm and abuse.

There were enough trained staff to support people with their needs.

Staff had been recruited using a robust recruitment process.

Systems were in place for the safe management of medicines.

Is the service effective?

Good ●

The service was effective.

Staff had attended a variety of training to keep their skills up to date and were supported with regular supervision.

People were involved in making decisions about all aspects of their treatment and care.

People could make choices about their food and drink and were provided with support when required.

Is the service caring?

Good ●

The service was caring.

People were able to make decisions about their daily activities.

Staff treated people with kindness and compassion.

People were treated with dignity and respect, and had the privacy they required.

Is the service responsive?

Good ●

The service was responsive.

Care and support plans were personalised and reflected people's individual requirements.

People and their relatives were involved in decisions regarding their care and support needs.

There was an extensive support programme, manned 24 hours.

The service had a black, minority and Ethnic (BME) outreach worker who worked closely with the wider community.

There was a complaints system in place and people were aware of this.

Is the service well-led?

Good ●

The service was well led.

People and their relatives knew the registered manager and were able to see him when required.

People and their relatives were asked for, and gave, feedback which was acted on.

Quality monitoring systems were in place and were effective.

Sue Ryder - St John's

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 12 and 13 April 2016 and was unannounced.

The inspection was carried out by two inspectors, two specialist advisors and a pharmacy inspector. The specialist advisors were specialists in end of life care and pressure care/tissue viability.

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. We checked the information we held about this service and the service provider. We also contacted the Local Authority. No concerns had been raised and the service met the regulations we inspected against at the last inspection which took place in November 2013.

During our inspection we observed how staff interacted with people who used the service.

We spoke with two people who used the service, one relative, the registered manager, the hospice director, the chaplain, the chef, the practice educator, the palliative care consultant, the ward manager, two staff nurses, two Partnership for Excellence in Palliative Support nurses and two health care assistants.

We reviewed three people's care records, three medication records, four staff files and records relating to the management of the service, such as quality audits.

Good ●

Is the service safe?

Our findings

People told us they felt safe at the service. One person said, "I feel very safe in my room. The nurses come as soon as I buzz." Another commented they felt very safe.

People were kept safe from avoidable harm by staff and volunteers who had received safeguarding training. Staff and management were aware of their responsibilities to protect people from avoidable harm and abuse. They were able to tell us what constituted abuse and how and when they would report any suspicions. There were notices of information giving telephone numbers and addresses of organisations they could report incidents or concerns to.

Each person had risk assessments in place to enable staff to support independence. These included the use of bed rails and tissue viability. Risk assessments had been reviewed as and when required. There were generic risk assessments for the service and for the environment.

Everyone who was at risk of developing pressure damage was cared for on appropriate beds and mattresses which had been set correctly. Body maps marking any lesions and turning charts were being used effectively to manage and minimise any identified risks.

An emergency file was kept by the front door. This contained the major incident protocol, contingency plan, floor plans and evacuation procedure. These would all be used to assist the emergency services in the event of evacuation. Each person had an individual Personal Emergency Evacuation Plan (PEEP) which was kept in this file. These were updated on a daily basis due to people's changing needs.

Checks had been carried out by contractors on fire extinguishers, call points and alarms. These were all documented. There had been no actions required.

All accidents and incidents were reported and reviewed by a member of the management team. These were then fed into the Quality Improvement Group meetings. This enabled the service to put into place any actions required to stop the accident/incident happening again if possible. We saw documentation which showed this had happened and fed back to the appropriate staff team.

There was an adequate number of staff on duty to provide care and support to people appropriately. Rotas we looked at showed a good skills mix of staff on each shift. The service had their own bank staff to call on to cover sickness and holidays. This helped with continuity of care as they knew the service well.

Safe recruitment practices had been followed. Each staff member had provided proof of identity, references and had a Disclosure and Barring Services check. Staff confirmed that they had not been allowed to start to work until all checks had been completed. Nurses PIN numbers showing registration with the Nursing and Midwifery Council (NMC) had been checked. Staff files we looked at confirmed this.

People received their medicines as prescribed on the Medication Administration Records (MAR). These prescriptions were written up and signed by a doctor employed by the service. We observed the preparation of a syringe driver containing pain relieving medicine for one person. A syringe driver is a small portable pump which can be used to give a continuous dose of painkiller and other medicines through a syringe. The medicine was a controlled drug which required extra checks to ensure it was handled safely. We noted that staff ensured that the preparation was double-checked by another registered nurse. The controlled drugs register was completed promptly when the medicine was administered.

People's medicines were supplied via stock medicines or on a named patient basis from the nearby Hinchinbrook hospital. People also received their discharge medicines from this site. A clinical pharmacist from the hospital visited twice a week and pharmacy technicians visited three times a week to top up stocks of medicines. This ensured the service held the appropriate amount of stock.

Medicines were stored securely, including controlled medicines. Administration and disposal of medicines were carried out safely, in line with current regulations and guidance. Controlled Drugs (CD) checks were carried out daily by two registered nurses. We saw evidence of daily fridge temperatures monitoring. This confirmed medicines were stored at the correct temperature to ensure their effectiveness. There was a robust procedure in place for the disposal of unwanted medicines, including people's own drugs if required.

At the time of inspection, no one was self-administering their medicines. Also there was nobody receiving their medicines covertly. Staff told us the procedures they would follow should one of these scenarios occur, with regards to ensuring people's safety in the use of medicines.

We saw evidence that staff that administered medicines received appropriate training relating to patient safety and medicines administration competency including drug calculation and this was repeated every two years.

We were informed that all staff members were encouraged to report incidents as a way of learning from mistakes that had happened, to ensure they did not happen again. We saw how medicines related incidents were reported and how learning from such incidents was shared and incorporated into policies and procedure to improve people's safety.

Good ●

Is the service effective?

Our findings

People received effective care and support from staff who had the necessary skills and knowledge. People we spoke with told us they thought the staff were well trained and always knew what they were doing.

The service had an induction programme for new staff to complete. We saw completed programmes which had been signed off as completed by a senior member of staff.

Staff told us there was a lot of training available. One staff member said, "Training is advertised on the notice board, there is always something on offer." Another said, "The training is really excellent." They went on to tell us they had been involved in writing some subject specific training for staff. A health care assistant told us they were encouraged to develop personally, for example; to do further general education to facilitate their nurse training if they wanted to. We saw staff had completed a variety of training including; health and safety, infection control and moving and handling. On the notice board were a number of upcoming training opportunities. Staff were also encouraged to complete nationally recognised qualifications. One staff member said, "I have finished my level two and have just started my level three diploma in health and social care." On the day of our inspection the Qualifications Credit Framework assessor was on site. She told us that the service was very supportive of staff who were doing their qualifications, and encouraged them at all times.

The service had their own practice educator. They were responsible for sourcing and developing training and making sure everyone attended what was required. On the day of our inspection a training session for moving and handling was in progress. The registered manager told us that they offered end of life training in conjunction with Hinchinbrook hospital. This was Quality End of Life for All (QELA) programme. Staff from the local hospital attended the hospice for five days training, three taught and two practical. This had been very well received and we saw feedback from nurses who had accessed it and it was positive. The registered manager told us that some of the hospital nurses who had completed the training had signed up to join the bank staff at the hospice.

Staff told us they were very well supported. We spoke with the person who carried out clinical supervision, they said, "Clinical supervision is really promoted." They went on to tell us that it was important so they could ensure staff were coping, due to the type of service. We saw a variety of supervision and appraisal records. We were told that the registered manager was always available to speak with. One staff member said, "He is very approachable, very caring."

The service had a large number of volunteers who carried out a variety of roles including; befriending, bereavement support, transport, reception and working in the shop. Volunteers we spoke with told us they received the same support as paid staff. We observed volunteers interacting with visitors, patients and staff. They spoke with kindness and compassion.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack 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. 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. At the time of our inspection no one using the service was subject to a DoLS.

People had signed consent forms where they had been able, for treatment and care. Some people had lasting power of attorneys in place and staff were aware of these. Staff had an understanding of their responsibilities under the MCA and we observed consent being sought throughout the day for a variety of reasons.

Some people had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPRs) in place when they arrived at the hospice. We saw where they were in place they had been discussed with the appropriate person and documented to ensure people got their preferred care at the end of their lives.

People told us the food was very good. We spoke with the chef who said, "When a new patient is admitted I like to visit them when they are settled to find out what type of food they like. I will get them anything they want if at all possible." They went on to tell us that there were only two people at the time who were eating so they were cooking just for them. Whilst we were in the kitchen the chef took a call asking for scones, a while later we saw fresh scones had been made. There were plentiful supplies of food in the stores. The chef had a good understanding of what constituted a fortified diet for anyone who needed it.

Menus were in each bedroom giving advice and what type of foods was available and that the chef would speak to people on their admission and at any time they requested.

People who were using the service had access to additional healthcare where required. The hospice offered most additional care which may be needed on site including; physiotherapy and complementary therapies.

Good ●

Is the service caring?

Our findings

People and relatives were very complimentary of the staff. One person said, "The staff are very helpful and kind. They would do anything for you." A relative said the care was 'unbelievable.' One person had been into the service for symptom control and was ready to return home. Their relative said, "It's a wonderful place, time for space, peace and quiet, but reassurance if help was needed, professionals are on hand. We are delighted that we had time here and feel confident about going back home."

It was obvious from our observations that staff knew people as well as they could do. They were able to tell us about individuals in their care and the contents of their care plans. This ensured that people received the care they requested which would help with their care and treatment. Staff were also courteous to other staff and worked as a team.

The service had an onsite chaplain who was available at any time to provide spiritual and emotional support. We spoke with the chaplain who was very supportive of the service and staff. The chaplain explained that staff could sometimes find the demands of their role stressful, so they were always available to listen to staff if they needed someone to talk to. We observed the chaplain discussing a person using the service with the doctor. They were discussing how they could minimise the person's stress and help them to cope with their approaching death. This was done in a discreet and compassionate way.

The service had a non-denominational prayer/peace room. The chaplain told us, "We have a variety of different objects and artefacts from a variety of differing faiths. This enables anyone of any faith to use the room and facilities." They also told us they were able to contact religious leaders from the local community at people's request. The chaplain explained that although they carried out a lot of funerals, as part of their role in supporting people with their spiritual welfare, they also conducted weddings. The day after our inspection a member of staff was getting married and the hospice chaplain was conducting the service.

The chaplain had set up a group for relatives and friends who had lost a loved one at the hospice. This gave them an opportunity to meet knowing that everyone had gone through a similar experience of bereavement. There was a memory tree in the prayer/peace room where anyone could write a note about a loved one and put it on the tree.

The service had their own bereavement service. This provided support on a one to one basis via the telephone, as a home visit or a visit to the service. There was a quiet room which could be used for this. We spent some time with staff discussing the service provided. They told us it was provided by volunteers who were specifically trained in bereavement support. They told us, and we saw, that there was a book of remembrance in the prayer room where loved ones names were written and families were invited to visit to look at the book when they wished. They also held a memorial event three times a year when friends and families had been invited to attend. The service had a number of information leaflets to assist families with emotional and practical, including their own booklet of guidance on what to do after a bereavement. This included local telephone numbers and opening times of official offices.

People were involved in discussions regarding any advanced decisions they wished to make. This could range from; what treatment people wanted, or did not want, where a person wished to die, or who they wanted to be with them. Documentation we reviewed showed this had taken place, recorded and reviewed if necessary. The registered manager told us that an advocate could be arranged for anyone who wished to have one.

There were single and dual occupancy rooms, although on the day of our inspection only single rooms were being used. There were privacy curtains in the duel occupancy rooms. The registered manager told us that people would only share a room if they were in agreement and were not on end of life care. People's privacy and dignity was observed to be kept. We observed staff knocking on doors and waiting for a reply before entering, and if they needed to discuss a persons care or treatment, this was done in the office for confidentiality.

Visitors were welcomed at any time. The service had folding beds which could be used by family members who wished to stay. There was a dedicated wet room for visitors to use. The service had a variety of areas, along with extensive grounds, which visitors and people could use for quiet time away from the main building.

Good ●

Is the service responsive?

Our findings

We saw in care plans we viewed that people and their relatives/representatives, where required, had been involved in their care plan. People's wishes were documented and staff carried these out. Staff we spoke with told us that it was very important to spend as much time as necessary with individuals to get as much information as possible as to their requirements. Quite a few people were known to the service from using their other resources. This assisted when people became in patients as they may already have met some staff and were known to them.

People were encouraged to maintain relationships with friends and relatives. There were no restrictions on visiting. The service had a bright lounge and a large conservatory which could be used to allow people to move to a peaceful area to relax at a difficult time. Well behaved pets were allowed to visit with prior arrangements.

The service had a family support team who helped people and their relatives with daily practicalities, for example how to apply for benefits, transport and any help required. The service had recently added a social worker to their staffing. This enabled support to be available to people and families when required on a daily basis without them having to go elsewhere.

The registered manager told us that the service sent out satisfaction surveys to ex patients or bereaved families three months after their loved one had passed away. Some comments included; 'thank you to the staff, [name] has returned home a new man.' 'All the care and attention I could possibly want has been given.' 'Everyone is so friendly, nothing is too much trouble.' And, 'Everything is discussed and explained.' Results from these were analysed and we were told if required action plans would be put in place and used to improve the service. The service also used 'real time' feedback. This entailed a member of staff or a volunteer spending a short time with a person using the service or their relative to get their opinions. This was also used alongside the satisfaction surveys, but if there was a particular issue it could be resolved immediately.

The complaints procedure was in the guidance given to each person when they arrived at the service. It set out how to complain and the expected response. There was a complaints policy in place. There had been no complaints received.

The hospice offered a befriending service. They responded to referrals from GP's, district nurses and the day hospice. They completed a short assessment to enable them to match a volunteer with the person to ensure they had a common bond. One of the staff said, "I love it, it's the best decision I have ever made to be working here, and it is very rewarding. We make a difference even if it is only for a short time." They went on to tell us about individuals and how the service had helped.

We found a child friendly area which was bright and cheerful with murals on the walls, books, games and a very large cuddly Charlie Chimp. These were to enable children to have their own area within the hospice to help them come to terms and accept what was happening to a loved one. The family support team had developed a programme called Charlie Chimp. This included a work book which was given to each child to complete on their own or with the help of a parent of a member of the family support team. When completed they discussed it and were given a toy Charlie Chimp. This could be used as a memory tool or they could give it to the person in the hospice. The staff told us this was well used and received.

The service had employed their own Black, Minority and Ethnic (BME) outreach worker. They explained their role was to introduce the hospice and the services it could offer to BME communities and hard to reach areas, and to clarify how they could be accessed. They had introduced themselves to doctors, district nurses and other professionals. They had been to a variety of places of worship and had gained leaders confidence enabling them to meet with different people, and had established a link person for each faith group. Following from this the outreach worker had organised an interfaith evening at the hospice where someone from each department gave a short talk on their role and area they supported. The outreach worker told us that the hospice had recently admitted some people from these communities. A range of specific information had been produced including a booklet and a DVD. The DVD had been produced with the help of the relatives of BEM people who had used the hospice services. This was in the process of being translated into six different languages. A dietary information leaflet had been produced covering different cultural and faith dietary requirements. This was discussed in consultation with the chef and copies were available for all staff and in the patient information packs.

The hospice had a service called Partnership for Excellence in Palliative Support (PEPS). This was run in partnership with Bedfordshire Clinical Commissioning (CCG), Sue Ryder and other healthcare providers. The aim of PEPS was to provide assistance for patients and carers at home. Patients were given a 24 hour helpline number which was manned by qualified nurses and offered a single point of contact. As well as offering advice and support, PEPS nurses were also able to co-ordinate other services to patients and their carers. Services included; crisis intervention, this could consist of several visits a day for up to three days until the crisis was resolved or other services were in place. This could include personal care, siting with patient or general emotional support. They also offered a hospice at home service and could provide end of life care by nursing assistants. This enabled continuity. The hospice at home service had the support of the hospice doctor to cover any medical issues.

The consultant explained to us a new service they had developed. It had come to their attention that a local prison had very limited end of life knowledge or support. After working closely with the prison authorities there was now an agreement in place to enable prisoners requiring end of life care to be transferred to the hospice. Close security arrangements were in place and prison staff would be with the person, the consultant told us they had done this twice and it had worked well. This was an innovative service which the consultant hoped could be grown.

The hospice had a day treatment facility. This provided a number of treatments which would otherwise have to be accessed at a hospital. It enabled people to have their treatment in a relaxed way with very little waiting time and with familiar staff. Complementary therapies were also offered to people including; aromatherapy, Indian head and Swedish massages, reflexology, reiki and aromatherapy. These offered a holistic approach to the care of people.

Good ●

Is the service well-led?

Our findings

There was an open and transparent management team. Staff and volunteers knew who all the management team were and were observed conversing throughout the visit.

The registered manager knew what was happening on a daily basis as they were on the floor alongside staff and volunteers. He was able to tell us which people were in the in-patient unit and the staff on duty. Staff told us, "He is around on a daily basis. He knows what is happening."

The director spoke of the future vision for the hospice. He told us how they hoped to progress in the future to fulfil the local area requirements.

The service carried out a variety of quality assurance audits. These included clinical quality monitoring and health and safety. Reports from all of these were fed into the Quality Improvement Group (QIG) who met every six weeks. We saw minutes from these. As a result of this group the provider was in the process of starting a Drug and Therapeutics Medicines Committee. This would include wider multidisciplinary team members with the purpose to promote rational, effective and economic prescribing which was in–line with national and local best practice guidelines. Outcomes from this group were fed back to staff at team meetings.

The service had a user group who met on a monthly basis. There had been a meeting on the evening of the first day of our inspection. The group was to get a rounded view of the services supplied and to get the views of people and relatives of people who were or had used the service. We saw minutes of meetings and some suggestions had been acted on. This included staff now getting real time feedback by asking people for their opinions as they happened. The group were also consulted when new information leaflets were being produced to make sure that what the service was saying did actually happen.

A variety of meetings were held regularly including nursing team and the domestic team. Each week there was a Multi-disciplinary Team (MDT) meeting. This was held on the day of our inspection and an inspection team member was invited to sit in. This was attended by the registered manager, consultant, doctors, head of clinical services, ward sister social worker and family support. This meeting was used to discuss patients and services offered.

Staff were aware of their roles and responsibilities and knew who to report to. This enabled the smooth running of the service as staff followed the correct reporting system. We saw in documentation that staff had been supported to report any issues they had or to report any errors. The provider had a no blame culture, but met in a variety of groups to find ways to improve practice if required. These were then fed back to staff during team meetings.

The service was innovative with the provisions they had recently implemented, for example the PEPS service and the BEM outreach worker. This showed they were aware of the local community needs and had responded positively to them to provide the appropriate services. The palliative care consultant told us they were in the process of looking at the recording of care and treatment records to streamline them for ease of use. They would be moving to an electronic recording system in the near future.