Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

St Oswalds Hospice

Regent Avenue, Gosforth, Newcastle-upon-Tyne, NE3 1EE

Tel: 01912850063

Date of Inspection: 08 January 2013

Date of Publication: January 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Management of medicines	✓ Met this standard
Supporting workers	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	St Oswalds Hospice
Registered Manager	Mrs. Angela Egdell
Overview of the service	St Oswald's Hospice provides specialist care for people with life limiting illnesses, including day and inpatient services for children, young adults and adults.
Type of service	Hospice services
Regulated activities	Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

	Page
Summary of this inspection:	
Why we carried out this inspection	4
How we carried out this inspection	4
What people told us and what we found	4
More information about the provider	5
Our judgements for each standard inspected:	
Consent to care and treatment	6
Care and welfare of people who use services	8
Management of medicines	10
Supporting workers	12
Complaints	14
About CQC Inspections	15
How we define our judgements	16
Glossary of terms we use in this report	18
Contact us	20

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 8 January 2013, talked with people who use the service and talked with carers and / or family members. We talked with staff.

What people told us and what we found

People using the day hospice told us they make their own choices about how to spend their time. One person commented, "The staff are fantastic and nothing is too much trouble. You can do as much or as little as you want, the patient is very much in control."

People told us how they maintained or developed their life skills such as spending time out of the hospice and accessing the day hospice to undertake a range of activities such as arts and crafts, music and trips out, for example to the cinema. One relative described how staff supported the whole family and commented, "Staff look after me, listen to me and ask how I am."

Medicines were handled appropriately. We saw the provider had comprehensive systems for monitoring medication which people brought into the hospice with them and managing medication administered to people. All staff had completed safe handling of medicines training and had their competency assessed annually.

Staff told us they felt well supported by managers and each other. Staff told us the provider was very supportive about them working towards further qualifications and attending additional training such as blood transfusion and bereavement training.

People told us they were aware of the complaints system and understood how to complain if they were unhappy with their care or treatment. No-one we talked with had any concerns and one person commented, "I have nothing to complain about, the staff and volunteers are amazing."

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

Staff told us care and treatment was patient-led and they always sought people's consent, or that of their relative, before providing care or treatment. One staff member commented, "We 100% ask patients first for anything." We observed on numerous occasions that staff knocked on people's doors and asked for permission before they entered the person's room. People using the day hospice told us they made their own choices about how to spend their time. They said staff went out of their way to support people with anything they wanted to do. One person commented, "The staff are fantastic and nothing is too much trouble. You can do as much or as little as you want, the patient is very much in control." This meant before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

We looked at records and found they were all signed to show formal consent to care and treatment had been obtained. This included assessments, care plans and other examples of formal consent, such as consent to take photographs and to use people's own medication. Staff in the children's hospice told us all paperwork including assessments and care plans were completed jointly by staff and parents. We saw from care records that specific parental requests were recorded and followed. For example one parent had specified a certain bedtime for their child and care records showed that this request was respected. People in the adult in-patient unit told us staff clearly explained things to them and never forced people to accept care or treatment.

We spoke with family members who said staff always involved them in decisions about their relative's care and updated them every time they visited. One family member commented, "Staff and volunteers are amazing. They are always smiley and happy and can't do enough for you." The staff we spoke with talked about people's rights to make their own decisions, including refusing care and treatment. This meant people were encouraged to express their views about the care and treatment they received and staff respected their views.

Staff described the formal processes that were followed when there were doubts about a

person's mental capacity to make decisions about their care and treatment. Staff told us, and records confirmed, they had completed training in the use of the Mental Capacity Act. Staff said decisions about capacity and best interests were made by a multi-disciplinary team of professionals. This meant where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

People's needs were assessed and care was planned and delivered in line with their individual care plan. We saw care files contained detailed information, including a family tree, a social history and a full medical history. Holistic assessments had been undertaken following people's admission into the hospice. Part of this assessment was to gather people's views about why they had been admitted. This included identifying goals and priorities, such as 'end of life' care, symptom control, emotional support and pain relief. Staff told us the admissions process included providing information about what the hospice can offer to people and introducing the social work team and multi disciplinary team of professionals. They also told us people were given a physical examination by medical staff and were observed to establish a baseline for deciding on appropriate care and treatment. This meant people were involved in assessing their needs and their views were taken into account as part of the assessment.

Comprehensive care and treatment plans had been developed following the initial assessments of people's needs. Core care plans covered a range of areas including nutrition, elimination, dyspnoea (breathing), hygiene and skin care. We saw individualised care plans had been developed where specific needs were identified, for example, mouth care and pain control. Staff used a body chart to help people identify the source of their pain. We saw from care records staff and patients had jointly completed a quality assessment, which considered people's perceptions about what was important to them. The assessment was scored on admission and again on discharge, which allowed staff to measure whether progress had been made with meeting their priorities. Staff told us care plans were reviewed regularly. They said the multi disciplinary team held a weekly 'review and planning meeting' where every patient was discussed. For example the team discussed care and treatment, identified key areas for the following week and agreed an action plan for each person. Actions were followed up at the next meeting. In addition to the weekly meeting staff also met daily to discuss people's care and treatment. We saw the whole multi disciplinary team completed evaluation sheets every day which allowed staff to build a comprehensive picture of what was happening with each person. This showed care plans were kept up to date with changes in people's health and contained relevant information to help staff provide appropriate and safe care and treatment.

People told us how they maintained or developed their life skills. For example, one person said staff had supported them to spend time out of the hospice and were there to offer

support when they returned. People also said they could access the day hospice to undertake a range of activities such as arts and crafts, music and trips out, for example to the cinema. One relative described how staff supported the whole family and commented, "Staff look after me, listen to me and ask how I am."

Care was planned and delivered in a way that was intended to ensure people's safety and welfare. We saw from care and treatment records staff undertook a range of assessments to establish whether people were at risk. For example assessments included screening for risks associated with poor nutrition, pressure areas, falls and mental health. Records showed risks were thoroughly assessed and measures to minimise and manage identified risks had been sensitively recorded. Risk assessments took account of people's vulnerabilities due to their health condition. We also saw examples of where staff had taken action to deal with changes in people's health. For example one person had been referred to a dietitian for advice due to reduced food intake and weight loss. This showed that staff took action where required to ensure people's safety.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

The provider had comprehensive systems for monitoring medication brought into the hospice and managing medication administered to people. The hospice's own stock medication and associated records were stored securely within locked cupboards in a locked room. Staff told us only the manager, staff nurses and the pharmacist, employed by the provider, had access to the medicine store. We saw that two members of staff sign-in medication received from the pharmacy. In most cases staff administered people's own medication and this was stored in a locked cabinet at the person's bedside. Staff said the medication policy had recently been updated to reflect this. Staff recorded details of any controlled drugs people brought into the hospice. People who used the service, or their relatives, had signed a specific consent form which allowed staff to use and dispose of their medicines. We saw the provider kept detailed records of drugs disposed of and had appropriate systems in place to dispose of unused drugs. This meant systems were in place to ensure medicines were handled appropriately.

Staff told us they currently did not have any people self administering their own medication. However, they said that because some people had previously chosen to self medicate, the provider had devised a specific policy to help ensure people were safe. Appropriate arrangements were in place to record the administration of medicines. We saw medication charts had been suitably completed and staff had signed charts each time medication was given. People told us they had no concerns about their medication. This meant medicines were given to people appropriately.

All staff had completed safe handling of medicines training. Staff told us all new nurses had their competency assessed. They also said nurses had their competency reassessed annually. We were told any issues identified with the handling of medicines were acted on. For example two nurses have undertaken additional training following the identification of concerns.

We saw a series of 'Standard Operating Procedures' relating to medication procedures had been developed jointly with the pharmacist to provide additional guidance for staff. These covered areas such as ordering stock medication and discharging people with medication. Staff told us a specific medication advice line, which was shared with another hospice, provided advice and support for external providers of palliative care, such as GPs and Macmillan nurses. On call medical staff provided drug advice for hospice staff. This

meant staff had a good understanding of the medication procedure and had easy access to additional advice and support if they needed it.

We also saw that a pharmacist, employed by the hospice, carried out various weekly and monthly medication audits. Medication audits were also undertaken by other members of the staff team including doctors. The manager told us any incidents relating to medication were reported and followed up, including any changes made to improve staff practice. The manager said findings from audits were used as a learning tool to improve practice. For example 'do not disturb' signs on doors were introduced as a result of medication audits. We were told the Medicines Management Group, which was made up of hospice professionals, reviewed any medication audits, drug alerts, policies and procedures. Minutes from the meetings were kept and fed back to staff during monthly briefings. This meant the provider had systems to review and improve its medicines management procedures.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

Staff told us they felt well supported by their managers and each other. One staff member commented, "I feel well supported, all the team support each other." Staff said the nature of their work can be traumatic at times so debriefing sessions and reflective practice were undertaken when required. They also said the team met regularly every month. Staff also told us and records confirmed staff received regular supervision with their manager. We saw the provider operated an annual appraisal system which included personal and professional development. The provider held monthly briefing sessions to ensure staff were aware of what was happening in the hospice. This meant staff were kept up to date with changes and felt well supported to do their job effectively.

We saw mandatory training was closely monitored to ensure training was up-to-date. The provider had electronic systems which monitored training requirements and identified when updates were required. We were advised these were in the process of being updated. Staff told us the percentage of staff and volunteers that had completed each mandatory training course was reported to management monthly. We saw most training was up-to-date, particularly due to the flexibility and availability of in-house training courses. Non-attendance at training was reported to the Risk Management Group and the Hospice Management Group. The provider told us they brought in external expertise for some training, such as moving and handling. This meant the provider had robust systems in place to ensure staff were fully trained to effectively carry out their roles.

Staff were able, from time to time, to obtain further relevant qualifications. Staff told us the provider was very supportive about them working towards further qualifications and attending additional training. For example, they said healthcare assistants were working towards National Vocational Qualifications and other staff had completed various training courses such as blood transfusion, mentoring and bereavement training. All clinical staff were required to complete a clinical education programme and clinical skills programme, led by a doctor and a nurse. These covered a range of clinical areas such as nausea and vomiting, the Liverpool Care Pathway, pain control and spirituality. This showed the provider was positive about training and encouraged staff to develop.

The provider had developed its own management programme called DELTA (Development, Education, Learning, Training and Achievement). Participants had an action plan which identified development areas for the future and suggested options to

resource their individual plan. The programme covered areas such as disciplinary and grievance procedures, managing absence and equality and diversity.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available.Comments and complaints people made were responded to appropriately.

Reasons for our judgement

Information about complaints was made available to everyone who used the service. We saw people were given a 'welcome pack' when they were admitted to the hospice and this included a copy of the complaints leaflet. The leaflet was written in an easy read format and included information about how to complain and how to get help with making a complaint. We also saw information about the complaints process was displayed in the reception area. This meant people were made aware of the complaints system in a format that met their needs.

People told us they were aware of the hospice's complaints system and understood how to complain if they were unhappy with their care or treatment. They confirmed they had been given written information about how to complain and said staff had talked to them about the complaints process. People said they felt any concerns they had would be dealt with fairly. People confirmed they felt confident about complaining. They said they had not had any concerns about how they were cared for or treated and had not previously made any complaints. One person commented, "I have nothing to complain about, the staff and volunteers are amazing." This meant people had their comments and complaints listened to and acted on, without the fear that they would be discriminated against for making a complaint.

We found there had been no complaints received in the last 12 months. However, staff told us they had systems in place to manage and monitor any complaints received. Staff said they had used postal surveys to ask people if they were aware of the hospice's complaints processes. Staff also told us they were currently analysing comments made by people during the previous 18 months to look for trends and patterns. Staff said the findings, when available, were to be discussed at an operations meeting and fed back to people who used the service. Staff also told us they tried to pre-empt concerns from developing into formal complaints by dealing with situations as they happened. For example feedback from people indicated food was not always hot enough. The provider took immediate action and purchased a new heated food trolley to resolve the issue. This meant the provider took people's comments seriously and took action to resolve issues at the earliest opportunity.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk