

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

Cotswold Care Hospice

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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
Meeting nutritional needs	✓ Met this standard
Management of medicines	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Cotswold Care Hospice
Overview of the service	Cotswold Care Hospice supports people with life limiting illnesses and their families. The service runs a day therapy service, an outpatient service, 'Hospice at Home' and a counselling service.
Type of service	Hospice services
Regulated activities	Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury

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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 20 March 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

We spoke with nine people, staff, the head of care and chief executive.

People attending the hospice were happy and pleased with the service. One said they looked forward to attending and spoke about the benefits of the service. They told us they only had to wait a short time between referral and provision of service.

People receiving a service at home were pleased saying "we couldn't have better treatment", "a remarkable service" and "I am really pleased as it gives us time for a rest". One person who was recently bereaved told us "they were perfectly wonderful, a great help to my partner and great support for me".

Staff were enthusiastic. The chief executive said it was a "great place to work". One staff we spoke with said it's a "great thing to be involved in, it means that there are more opportunities for families to have their relative at home".

We saw compliments. We read some of the comments people made about the service. They included "Thank you so much to every one of you who provide such a wonderful place to come and relax, laugh and cry and give us such support. Without you, I would never have got my 'life' back and become 'me' again"

People said staff obtained consent before assisting them or their relatives. Staff confirmed that they only supported people in taking medicines. Staff and volunteers who had been subject to rigorous checks. People knew how and to whom they should complain. We saw that complaints were investigated fully.

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.

Reasons for our judgement

The guide to services provided at Cotswold Care Hospice outlined how people would be consulted about their care and treatment and given choices. It assured strict confidentiality and made reference to how people would be asked to give consent to treatment and the sharing of information.

The consent policy stated that valid consent must be obtained before any treatment or personal care could be provided and cited it as a general legal and ethical principle that this happened. The policy differentiated types of consent as implied, verbal and written. It gave information about mental capacity as outlined in The Mental Health Act 1983 and Mental Capacity Act 2005.

We saw that people were asked to sign to give consent to the sharing of information about them and were informed that this would only be done when required and in certain circumstances.

Where counselling services were provided consent was seen by hospice staff as a form of 'contract' that maintained confidentiality.

Staff we spoke with who worked for 'Hospice at Home' told us they always told people what they were about to do for them and obtained their agreement as consent to support.

The hospice provided a single point of contact for people. In addition to referrals being made by healthcare professionals' people could refer themselves for a service. They could also be referred by a friend or neighbour and on these occasions the service ensured that people had given their consent to the referral being made.

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

Cotswold care worked in partnership with a range of NHS providers to offer specialist care and provided space to enable these visiting services.

When a referral was received people's needs were assessed and they were provided a service according to criteria that assessed their level of priority. People we spoke with said they did not have to wait long between referral and being assessed for a service.

The assessment of wellbeing tool was used to record how people felt about their illness and identified their personal goals. We saw care plans that recorded concerns and described the issues people had. They identified what help was already available and indicated the support to be provided by the service and set a date for review.

People were also assessed against a performance scale index (Karnofsky). This allowed them to be classified according to their functional impairment with the lowest scale being the worse for survival of an illness.

Cotswold Care provided a range of services including day therapy, an out-patient therapy service and 'Hospice at Home'. We saw that once assessment was completed people were sent a letter to confirm the service that had been agreed.

Day therapy was available on three days each week. People attended one day each week for up to 12 weeks. Their attendance was reviewed at the 10 week stage. This was to consider whether people had been sufficiently supported and therapy could be extended following the review, if necessary.

Day therapy included nursing care, physiotherapy, counselling, pastoral care complementary therapy and creative therapy. People were allocated a 'key worker' to coordinate their care and act as a point of contact for them. Each time people attended for day therapy they would spend time with their key worker who would later record the discussion they had about the person's well being.

Counselling was provided in one of the dedicated rooms at the hospice. This was to support people when they had been diagnosed with a life limiting illness and for their families when they were bereaved. The service employed two counsellors and there were

specially trained 'bereavement volunteers' to support people. Counsellors were registered with the British Association for Counsellors and Psychotherapists. Guidelines produced by the National Institute for Clinical Excellence (NICE) were used to gauge whether people could be supported by the service. Counsellors could support people up to a certain level. If they were considered to need specialist mental health services they were referred to the NHS for support.

In addition to face to face meetings with a councillor there were opportunities for people or their families to join group sessions in the 'Sanctuary'. These included bereavement counselling. A leaflet was made available to people who were in 'grief'. The intention of the information was for anyone who had been bereaved and gave guidance to help people understand how they were feeling.

The manager told us that people were encouraged to consider 'advanced care planning' for the period leading up to point of their death and beyond.

Complimentary therapies such as Reiki, reflexology, aromatherapy massage and art therapy were provided at the hospice. There were dedicated treatment rooms for Reiki and aromatherapy along with the 'creative space'. One of the therapy rooms had a specialist couch to enable treatments for larger people (Bariatric).

We saw the range of art people achieved during their time in the 'Art for Health' group. This included drawing, painting, pottery, glass craft and silk painting. We looked at the care file for one person who attended the group. When a review had taken place the therapist had recorded the person "said he feels his counselling sessions have helped and he understands himself a lot better. He feels 'more free' and more able to have fun with art". The chief executive told us that art therapy provided people with a focus for the future and enabled the service to 'sign-post' people to future activity.

The 'Hospice at Home' service supported people, as assessed, throughout the day and night in their own home. There were on call arrangements, out of normal working hours, to enable people to contact the service and to support staff. The service included registered nurses and health care assistants. About 24,000 hours of service were provided each year.

We looked at four care files for people who used the day therapy service and at five for people receiving a service from 'Hospice at Home'.

The care files for people who attended for day therapy contained the referral form listing all relevant information including the details of the person for whom the referral had been made. It listed the type of service required along with the status and site of the person's condition and date of diagnosis. The chief executive explained that the closer to the date of diagnosis the referral for day therapy was, the longer the benefits would last.

The assessments of well being had been completed along with the 'Karnofsky' performance status. There were records of medicines and moving and handling assessments. Care plans set agreed objectives and we saw evaluation of the actions taken to achieve the goals. People were sent a 'discharge letter' at the end of the service when agreed goals had been achieved.

The files for those who used 'Hospice at Home' included the completed referral form showing people's personal details and those of their carer. There were medical and care details listed along with information about whether the person wished to be resuscitated.

Care plans and records of contacts were in place. Where care needs changed we saw these were recorded. 'Hospice at Home' staff followed the district nursing care plan and made entries in nursing notes. In the case of the record of a person who had recently died, the date of death was recorded.

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were provided with a choice of suitable and nutritious food and drink.

Reasons for our judgement

We saw that refreshments were available for when people arrived for day therapy. There was a selection of cakes, biscuits and fresh fruit available with drinks.

Lunchtime was a time when people got together. Mealtimes were supported by 'hospitality volunteers' who helped to serve meals and drinks. We sat with people as they had their meal and noted it to be sociable with lively conversation. We observed that people made friendships quickly, talked about their time at the hospice, their condition and supported each other. People told us "everything's brilliant" and "I look forward to Wednesdays". One person said they looked forward to the respite day therapy provided.

Dining tables were set with crisp linen table cloths and napkins and decorated with fresh flowers. There was a choice of main dishes served with vegetables and portion sizes were good. Food was attractively presented and people's preferences and dietary needs were met. Dietary needs were considered as part of the assessment process.

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

We saw the medicines management policy. It outlined how the hospice was committed to ensuring the safe handling of medicines to protect people and staff. It was set within a legislative and professional practice framework and stated that the head of care was responsible for ensuring that all clinical staff were trained and competent in all aspects of administering medicines.

People attending the hospice for a day service managed their own medicines usually but in some circumstances it was necessary for staff to assist them. The hospice had secure storage for medicines for when people brought dangerous medicines into the service.

The policy outlined the procedure for administering medicines, recording and disposal of medicines. In addition there was specific reference to arrangements for controlled (dangerous) medicines, for when people had adverse reactions and for when errors in administration occurred.

'Hospice at Home' staff would only support and encourage people to ensure they took their prescribed medicines. The two staff we spoke with from the service confirmed this.

There were assessments that identified whether there were any risks to people administering their own medicines. It considered areas of competence listed as understanding the regime for taking medicines along with safety and recording of medicines.

People were asked to notify the hospice of any changes to their medicines so that their records could be kept up to date.

Requirements relating to workers

✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff and volunteers.

Reasons for our judgement

The hospice ran with paid staff and volunteers. We spoke with staff and volunteers who were enthusiastic about the service and their involvement.

We spoke with the head of human resources who told us about the procedure for recruiting into new and replacement posts. They said that job descriptions were produced for new positions in the service and reviewed when recruiting for a replacement position. The service advertised locally for staff e.g. 'Hospice at Home' and more widely for some other posts as appropriate.

There were effective recruitment and selection processes in place. Application forms were required to be completed in all cases that required details of the applicant's employment history, education training and qualifications, training attended and supporting information. References were obtained in addition to an enhanced Disclosure and Barring Service check (DBS).

Applications were made anonymous for the short listing process and for the interview stage there was a record maintained. Applicants were 'rated' according to the responses they gave in response to the interview questions and the most successful applicant was offered the position.

We saw that successful applicants were required to complete a pre-employment health questionnaire and provide proof of identity. They were required to sign the offer letter as an indication of acceptance of the position and were then given a statement of terms and conditions of their employment with Cotswold Care.

Competency was gauged as part of each staff members' probationary period and only if they fulfilled the requirements of the role they were confirmed in post.

The head of human resources told us they sensed that "everyone was proud to be working here". Staff from the hospice and those who worked for 'Hospice at Home' told us they enjoyed their job with one person adding "the people I work with are passionate about their work"

The volunteer coordinator echoed this when asked if they wanted to say anything about working for the service telling us "it's amazing! It's a lovely place to work".

They told us about the recruitment 'pathway' for volunteers. There were role 'profiles' for generic and specific types of volunteers outlining the expectations of the role. The profiles listed the responsibilities of volunteers, the expected commitment from them and the essential qualities of people who volunteered to work for the service.

Volunteers were required to assist in the running of the hospice, as drivers to transport people to and from the service and to work in the charity shops that supported the fund raising for Cotswold Care.

People who wanted to volunteer to work for the service were required to complete an application form, provide the names of two people who would provide a reference, visit the hospice for an informal discussion and submit evidence to enable a DBS disclosure to be obtained, if working directly with people who used services. Volunteers were expected to sign an agreement and to complete annual training in essential areas of safety.

In addition volunteer drivers had to provide evidence that showed they were eligible to drive and had adequate insurance arrangements in place. The hospice verified, by confirming their insurance, that they were covered to provide a voluntary service.

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

We saw the complaints policy, procedure and flowchart. Together they outlined how the hospice would respond to expressions of concern or complaint.

The 'Your comments matter' leaflet explained to people how they could comment on the service they received or complain. It gave a definition of complaint and stated the commitment of the hospice to improve services. It outlined the procedure for making complaints and the response people could expect. It also listed contact details for relevant organisations.

People's complaints were fully investigated and resolved, where possible, to their satisfaction. Seven complaints had been investigated by the chief executive in the last year. These were mostly related to the organisation other activities such as fund raising. Only one was directly related to the care service. It had been investigated, deemed unfounded as there was evidence to show that the service provided had exceeded what was requested. The chief executive had responded to the complainant and received an amicable reply.

Complaints were considered by the clinical governance group at its meeting held every two months. The chief executive told us they would be presenting a summary of the year's complaints at the board meeting that evening.

There were comments boxes in the hospice. We saw a comment that had been posted. It read "You are wonderful as you are, please don't change. I don't know what me and my husband would have done without you".

The chief executive showed us the new form that had been designed to gain feedback. It was based on the NHS 'Friends and Family Test' and provided a "mechanism to identify both good and bad performance and encourage improvements where services do not live up to expectations". The form asked one question "How likely are you to recommend our service to friends and family if they needed similar care or treatment?" People who completed the form were asked to indicate whether they would or not and how likely or unlikely it would be.

We saw letters and cards displayed around the hospice. We read some of the comments people had made about the service provided. They included "Thanks you so much for

helping my mum through her illness, she loved her 'pamper days'. You gave her peace, comfort and time to talk which is a wonderful gift. My mum was the best and deserved the best".

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.

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