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

### Dove House Hospice

Chamberlain Road, Hull, HU8 8DH  
Tel: 01482784343  
Date of Inspection: 05 February 2013  
Date of Publication: March 2013

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

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<td>✓</td>
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<tr>
<td>Care and welfare of people who use services</td>
<td>✓</td>
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<tr>
<td>Safeguarding people who use services from abuse</td>
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<tr>
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## Details about this location

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<tr>
<th>Registered Provider</th>
<th>North Humberside Hospice Project Limited</th>
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<tr>
<td>Registered Manager</td>
<td>Ms. Anna Wolkowski</td>
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### Overview of the service

Dove House Hospice is a registered charity. It provides In-Patient, Day Care and Out Patient services to people with a life-limiting illness. This is often, but not always cancer. Referral to use the service is usually by a doctor or specialist nurse, but people can refer themselves or their relative for support, if appropriate. No direct charge is made to people using these services.

### 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
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’.

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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 5 February 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 saw that the provider had held best interest meetings for their patients. Best interest meetings were held when a patient lacked the capacity to make an informed decision. We saw evidence that the meetings were attended by the patient’s Independent Mental Capacity Advocate.

The hospice employed a team of healthcare professionals, including consultants and social workers. A second year registrar told us that “Everyone’s opinion is heard, it’s fantastic how many professionals are involved with every patients care.”

The hospice had a number of policies in place to safeguard the patients who used the service from abuse. Amongst others, reporting of serious malpractice and abuse, safeguarding children, prevention of bullying and protection of vulnerable adults.

Appropriate arrangements were in place for the safe ordering, dispensing and disposal of medication.

We noted the hospice had a complaints procedure and an anonymous complaints policy. Two formal complaints were received in 2012; we saw that the complaints had been investigated and the findings had been shared in the clinical forum meeting, using each complaint as a learning opportunity.

We spoke with the Caldicott Guardian who explained there role in relation to record keeping “I am the conscience of the organisation, to protect patients confidential information”, “I work in partnership with the Senior Information and Records Officer whose role is the security of information.”

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 care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

Where people did not have the capacity to give their consent, the provider acted in accordance with legal requirements. A senior sister we spoke with said that "Peoples holistic treatment does not have documented consent; consent is given verbally." We were told "If a patient does not give consent then the reason for this is documented in the care plan."

We saw that on a number of occasions the provider had held best interest meetings for their patients. Best interest meetings were held when a patient lacked the capacity to make an informed decision. We saw evidence that the meetings were attended by the patient's Independent Mental Capacity Advocate (IMCA) and a number of healthcare professionals from different specialities. This ensured that the patient's holistic care and welfare was considered.

We saw a number of pieces of documentation in relation to consent, including; a Consent to Care and Treatment policy, a Consent Form (Patient Agreement to Care and Treatment), a Mental Capacity Procedure and a Advance Care Planning (ACP) policy. We were told that consent forms were signed for specialised treatment such as complementary therapies and we saw evidence of this in patients care files.

ACP is discussed with patients due to the nature of the service being provided; 'caring for people with a life limiting illness'. ACP captures a patient's aspirations in relation to their future care and treatment. A patients consent to share this information with other relevant professionals is documented in their care file.

A senior sister we spoke with told us that "When new patients come in we explain the room situation (patients may share a four bed ward) and gain their consent." A relative said "My wife does not want to be in a room by herself, it's not a time to be alone."

The education administrator told us that staff attended an accredited mental capacity act training course. We saw the provider's essential education training document and noted...
that mental capacity training was part of the mandatory training program. A care assistant said "I have done my mental capacity training" and went on to say "I just talk to people to get their consent; we must respect the patients wishes."
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

To gain an understanding of the care and welfare of the patients that used the service we looked at a variety of documentation including; four care plans, the organisations policies and procedures, an annual review report and staff training records. During the inspection we spoke with one patient, one relative, three volunteers and ten members of staff.

We saw evidence that multi disciplinary meetings were held every morning and used as a forum for each speciality to be updated on a patient's condition. We were told that "Our palliative care patients can decline so rapidly that care and treatment has to be reviewed on a daily, even hourly basis." Relevant professionals sharing their knowledge and insight about each patient ensured that the best and most appropriate care is being provided.

Care plans contained a number of risk assessments including moving and handling, water-low and the use of bed rails. We were told that a consultant will complete an assessment of the patient within one hour of their arrival to the hospice. Assessments captured information such as diagnosis and prognosis, mobility, breathing and eating and drinking.

The hospice employed a team of healthcare professionals, including consultants and social workers. A second year registrar told us that "Everyone's opinion is heard, it's fantastic how many professionals are involved with every patients care." We saw evidence that the hospice had contacted the falls team, district nurses, social service and the dietician to gain their professional opinion.

A care assistant told us that "We provide good patient care across the board; we draw on each others strengths to achieve the best outcomes for our patients." Then said "Everything we do is for the people that use the service and for their families, we try to walk the journey with them." A relative we spoke with told us "The care they provide has been absolutely first class, from the consultant down, they all have time for us" and "They arranged everything for me to support my wife at home, district nurses, oxygen, air products, inflatable mattress bed, carers to come in; everything." We were told by a patient that "The staff are really great, really something. It's far better than any other hospital I've ever been too."

We spoke with three volunteers who worked on the main reception desk, one person told us that "The service looked after my Nana; I work here to try and give something back."
Another volunteer said "They looked after my partner so well. They give you choices you did not know were available."

We looked at the new style care plans that the provider will introduce imminently. We were told that the new style and content had been accepted at a recent clinical forum meeting and that staff were undertaking person centred training to ensure they were used effectively.

Dove House Hospice received an award in 2012 for the 'outstanding care' that they provided to a patient with learning difficulties. The Palliative Care for People with Learning Difficulties (PCPLD) network recognised the outstanding care provided coupled with the deep understanding of his individual needs and the sustainable changes made to service delivery.
**Safeguarding people who use services from abuse**

Met this standard

**People should be protected from abuse and staff should respect their human rights**

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**Our judgement**

The provider was meeting this standard.

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent it from happening.

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**Reasons for our judgement**

The education administrator told us that "Child protection and safeguarding vulnerable adults forms part of our essential education programme." The training records we looked at provided evidence that all staff had completed this training. The essential education course was held on a yearly basis. Having a highly trained and competent staff team ensures that people using the service were safeguarded from all forms of abuse.

The hospice had a number of policies in place to safeguard the patients that used the service from abuse. Amongst others, reporting of serious malpractice and abuse, safeguarding children, prevention of bullying and protection of vulnerable adults. We noted that the protection of vulnerable adult’s policy’s front sheet had various contact numbers for local safeguarding teams.

The hospice had an unforeseen emergency plan that covers circumstances such as power cuts, gas leaks, fires and bomb threats. Having contingency arrangements in place gives assurance that the needs of patients who use the service will continue to be met before, during and after an emergency. The hospice had taken reasonably practical steps to safeguard patients from neglect.

We spoke with three members of staff that could independently describe what actions they would take if they suspected that abuse had occurred. We were told "I have just been on my safeguarding training; I would report anything I didn't like immediately." A sister said "I would do anything for my patients, they come first."

We spoke with a patient and were told that "I know I'm safe here, it's a fantastic place, I can't fault it."
Management of medicines

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

Appropriate arrangements were in place for the safe ordering, dispensing and disposal of medication. The hospice had a range of medication policies in place that outlined how to manage medicines effectively. We noted that the hospice had specific procedures in relation to the management of controlled drugs.

The pharmacist that we spoke with described the process for the safe destruction of controlled drugs "They are destroyed on site, following the royal pharmaceutical advice and guidance on controlled drug destruction." A senior sister said "Every night all the controlled drugs are counted and checked to make sure they match the controlled drug register, if there is a discrepancy then we have a procedure to follow." We saw evidence that monthly audits took place that ensured the accuracy of the daily checks.

The registered manager told us that "We expect all qualified staff to adhere to the administration of medicines policy as part of their code of conduct." She went on to say "We ensure people’s skills are up to date via appraisals and other meetings."

The hospice had a dedicated medicines room for the safe storage of medication. This included a second lockable cupboard within the room for the storage of controlled drugs and a medicines fridge to keep medication at cooler temperatures. We saw that temperatures of the fridge were recorded on a daily basis. The hospice had a specific bin for the safe disposal of sharps and a specific bin for chemotherapy products.

The provider may find it useful to note that, although the documentation used in relation to recording fridge temperatures stated that medication should be stored between two and eight degrees, on two occasions a higher temperature had been recorded. Failing to store medication at the temperatures advised by the manufacturer can cause medication to lose potency.
Complaints

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

On our arrival to the hospice we noted that a comments, compliments and complaints leaflet was available in the reception area. The leaflet outlined the timescales a complainant should expect to receive a full written response and included the details of who to contact if an unsatisfactory response was reached. It also had the contact details of the care quality commission in case a person felt unable to complain directly to the hospice.

During a tour of the building we saw that the hospice had a comments box so suggestions of improvement could be given informally. Monthly service user and relative meetings were held so that any concerns or issues could be raised and dealt with before they become a cause to complain formally. We were told by registered manager "I think we offer a high quality, we pride ourselves on the service we provide."

We noted the hospice had a complaints procedure and an anonymous complaints policy. Two formal complaints were received in 2012; we saw that the complaints had been investigated and the findings had been shared in the clinical forum meeting, using each complaint as a learning opportunity. This gave assurance that complaints were taken seriously by the provider, investigated to a conclusion and recommendations would then be implemented as required to improve the service where possible.

People had their comments and complaints listened to and acted on, without the fear that they would be discriminated against for making a complaint.

Feedback questionnaires were given to patients on discharge and a comment was received about the metal bins used around the hospice. The bins were replaced by 'soft closing' bins to reduce noise levels. A senior sister told us "We offer people lots of opportunities to express any concerns." Another sister we spoke to said "We listen."
### Records

**People’s personal records, including medical records, should be accurate and kept safe and confidential**

#### Our judgement

The provider was meeting this standard.

People’s personal records including medical records were accurate, fit for purpose and kept securely so they could be located promptly when needed.

#### Reasons for our judgement

During our inspection we looked at various documentation including; care files, training information and accident and incident records. Personal records were fit for purpose and kept securely. A sister told us that "There is enough information in the care files for you to know what care is required and people’s needs." A care assistant said "You need to use your fob to open the records cupboards, it is always locked."

We spoke with the Caldicott Guardian who explained their role in relation to record keeping "I am the conscience of the organisation, to protect patients confidential information", "I work in partnership with the Senior Information and Risk Owner (SIRO) his role is the security of information."

The hospice had a sharing of information form that was discussed with patients as they are admitted to the hospice to gain their consent. The social worker that we spoke with informed us of the process for sending private and confidential information via e mail "We encrypt the email and then call who ever we are sending it to and tell them the unique password."

The Caldicott Guardian explained that all staff must complete the information governance training online. The hospice archived records that were no longer in use and after an eight year period files were destroyed.
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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**Website:** www.cqc.org.uk

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