Inspection Report

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

Lindsey Lodge Hospice

Burringham Road, Scunthorpe, DN17 2AA

Tel: 01724270835

Date of Inspection: 02 January 2014

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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
Meeting nutritional needs	✓ Met this standard
Management of medicines	✓ Met this standard
Supporting workers	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Lindsey Lodge Limited
Registered Manager	Mrs. Alison Tindall
Overview of the service	Lindsey Lodge is a small purpose built service that provides inpatient care and treatment for a maximum of 10 people who have a life limiting condition. The service can also provide day care support for up to 14 people each day.
Type of service	Hospice services
Regulated activities	Diagnostic and screening procedures 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'.

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 2 January 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

What people told us and what we found

Patients told us staff asked for their consent prior to delivering care and treatment. Comments included, "They ask if it's ok for me to have a shower" and "They always ask if it's alright to take bloods." We found staff completed assessments of capacity and held best interest meetings when people were assessed as unable to make their own decisions.

Patients told us they enjoyed the meals provided and were offered choices and alternatives. Comments included, "I think the food is alright; I can't think of any improvements" and "They are brilliant in the kitchen and patients get whatever they fancy." We found patient's nutritional needs were met.

Medicines were managed safely and staff ensured patients received their medicines on time and as prescribed.

We found staff had access to a range of training relevant to their role. They were supported by senior staff and had annual appraisals. Comment included, "Management support is good. You can go to them with anything and they will take time out to sort out the problem."

We found the service had a complaints policy and procedure, which was available in each bedroom. Patients told us they would feel able to make complaints if required.

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

Reasons for our judgement

During the inspection we spoke with patients who used the service about how their consent was gained prior to care and treatment. We found before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Patients told us staff asked their permission before completing tasks and they felt able to make their own decisions and choices about their care. Comments included, "They ask if it's ok for me to have a shower" and "They always ask if it's alright to take bloods."

Staff told us they gained consent to care and treatment by ensuring patients were informed about what was to happen and speaking with them to check that it was ok to go ahead with tasks. Comments included, "We ask patients and get their verbal consent" and "We do speak with families and discuss options with patients."

We looked at a range of care files to see how consent was recorded. We found patients were asked their permission to share medical information with other relevant health professionals. In one of the care files we looked at, the patient had made clear decisions about end of life care and preferences for how this was to be carried out. There was an advanced decision regarding their wish to refuse specific treatment documented in the file. In another care file staff had recorded a discussion with the patient regarding catheterisation and stated they were happy with the procedure to go ahead.

Some patients had decided they did not want to be resuscitated if they had a cardiac arrest and others had made the opposite decision. The form for these decisions were completed with the patient and held in the care files. Staff were made aware of these decisions.

We checked the provider's consent policy and procedure. This specified the key principles of consent and stated, "Every adult has the right to make his or her own decisions and

must be assumed to have the capacity to do so unless proved otherwise." We found that where patients did not have the capacity to provide consent, the provider acted in accordance with legal requirements. Assessments of capacity were recorded in the care files and when it was decided a patient lacked capacity, best interest meetings were held. These enabled comments from family and other health professionals when making important decisions.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

Patients were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

During the inspection we spoke with patients about the meals provided. We found patients were provided with a choice of suitable and nutritious food and drink. Patients were supported to be able to eat and drink sufficient amounts to meet their needs. Comments from patients who used the service included, "I had eggs and bacon for breakfast and the eggs were just right", "I think the food is alright; I can't think of any improvements" and "If I won the lottery I'd give the chef a million pounds; the food is out of this world."

We spoke with catering staff and they advised there were no set menus. They told us the meals were decided on the day before. This was so patients who attended day service on specific days of the week had a varied range of meals prepared. The catering staff told us they had daily contact with nurses regarding inpatients. They visited new patients and spoke with them about likes and dislikes. Diets could be provided to suit a range of needs, preferences and health issues. Catering staff were aware that patient's appetites were often affected by their illness and told us they tried to ensure they had whatever they wished to eat. They said, "Everyone goes that extra mile to ensure they get to eat what they want." Nursing staff spoken with confirmed this and stated, "They are brilliant in the kitchen and patients get whatever they fancy."

We observed catering staff visited patients and discussed the menu with them. We saw patients were offered choices and alternatives. Patients could have a cooked breakfast in the morning and a three course meal was served at lunch and in the evening.

Patients had the choice of eating in the dining room or in their bedrooms. The dining room was light and airy and set out in restaurant style with tables and chairs to seat four people at each one. Inpatients, patients from the day service, relatives and staff had the opportunity to use the dining room. The kitchen server was attached to the dining room and there was a salad bar in one corner of the room. The daily salad bar added to the choices available.

Care files held information regarding patient's likes and dislikes and nutritional needs. Food supplements were prescribed for patients with a reduced appetite. Nursing staff told us patients would be referred to other health professionals such as dieticians and speech and language therapists as required. Care files looked at confirmed this.

We noted in one file that the patient received their nutrition via a tube directly into their stomach (PEG). The patient had made a decision to continue to eat their meals orally and there was documentation supporting this risk as the patient's choice. There was a care plan detailing care of the PEG and a statement regarding the risk of choking when meals were taken orally. Staff described the steps they took to minimise these risks, such as always having a nurse present when the patient ate their meals and ensuring food was cut up into appropriate bite size pieces. The provider may find it useful to note that although the staff could describe the steps to minimise risk, this information had not been recorded in the care plan or risk assessment. This could mean that new staff may not have full information about how to support the patient. This was mentioned to the senior nurse to address.

Nurses spoken with were mindful that patients could be upset with loss of weight during their illness. For this reason patients were not weighed unless they requested it. Catering staff used observation about food and fluid intake and liaised with nurses and medical staff when concerns were highlighted. This meant that nutritional issues could be discussed with the patient as they arose and steps taken to improve nutritional intake.

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.

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

Reasons for our judgement

During the inspection we spoke with staff about medicines management, checked the controlled drugs books and looked at a selection of patient records. We found appropriate arrangements were in place in relation to obtaining, administering, recording, storing and disposal of medicines.

Patients spoken with told us they received their medicines on time and had not been left in pain.

There was a standard range of commonly used medicines held in Lindsey Lodge which was supplied by a local pharmacy. These were stored in a secure treatment room. When patients brought in their own medicines from home these were stored in locked cabinets in their bedrooms.

There were systems in place for ordering medicines to ensure patients did not run out of their own stock. When patients brought in controlled drugs (CDs) these were stored in a secure CD cabinet in the treatment room. Medicines including CDs were returned to patients when they were discharged home or disposed of in specific denaturising kits when no longer required. This ensured that medicines were disposed of safely.

We found some patients received their medicines through a syringe driver, which ensured they received them at a steady pace to address pain control. Nurses spoken with told us they had completed training in how to set up and use a new model of syringe driver used in the service. Nursing staff administered medicines to patients and a senior nurse spoken with told us they were arranging annual competency tests to ensure practice was observed in this area.

We looked at some patient drug records, which were colour coded to assist staff. For example, when patients had medicines administered via syringe drivers these were recorded on a pink card. Regular medicines were written on a white card and 'when required' medicines on a blue card. We found some minor recording issues which were mentioned to the registered manager to address.

The service had three CD books; one was for patients own CDs brought from home, one was for the services own stock of CDs in frequent use and the last one was for CDs used infrequently. We checked these records and found accurate recording in each one with two signatures when CDs were administered. This ensured these specific medicines were countersigned to avoid mistakes.

We looked at the provider's policy and procedure for the management of medicines and found practice reflected this document.

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.

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

Reasons for our judgement

We found staff received appropriate professional development and were able, from time to time, to obtain further relevant qualifications.

We saw that in 2013, the service had an induction programme for all new staff and volunteers, which was run every two months throughout the year. This covered a talk about the hospice movement and palliative care. It also included awareness discussions on health and safety, hand hygiene, safeguarding vulnerable people, moving and handling, communication, confidentiality and fire safety. It concluded with a tour of the building. Qualified nurses completed a two week induction as an additional member of staff on the inpatient unit and a week on the day service unit. This enabled them to become familiar with how the two services were managed.

The registered manager provided us with a record of the training courses delivered in 2013. These included a range of topics to ensure staff gained the skills and knowledge required to complete their role. They were delivered by members of the multidisciplinary team, clinical and non-clinical hospice staff. Examples of some of these courses were palliative care, dementia awareness, nutrition, swallowing difficulties, acupuncture and acupressure, learning disability awareness, advanced care planning, pain management and carer support.

There was also a range of courses considered essential by the service such as moving and handling, cardio pulmonary resuscitation (CPR), health and safety, safeguarding, communication skills and infection control. These were delivered on a rolling programme every two months throughout the year and all staff were expected to attend each year. Reception staff completed specific training for their role.

Staff spoken with confirmed they received training which enabled them to feel confident in their role. Comments included, "I'm doing a palliative care course with York University and can do this half in my time and half in work time."

Nursing staff and a health care assistant spoken with told us they did not receive formal documented supervision. However, they told us they were supported and supervised on a

daily basis by senior staff. Comments included, "Management support is good. You can go to them with anything and they will take time out to sort out the problem" and "We have annual appraisals. Yes, I do feel supported."

Patients spoken with were complimentary about the staff team. Comments included, "I couldn't wish for a better bunch of girls here on the ward and in day care", "They are lovely, you can have a laugh and a joke with them", "They come in and check you are ok, yes I do feel looked after well" and "It takes a special kind of nurse to do this kind of nursing; they are very patient." One patient told us they experienced shortness of breath during the night and a nurse came and stayed with him until he recovered. He said he was grateful for this. A relative told us they too felt supported by the staff.

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 patients made were responded to appropriately.

Reasons for our judgement

We found patients were made aware of the complaints system. The complaints procedure was included in an information book provided in each bedroom. Patients and their relatives spoken with knew how to complain and said they would feel able to complain. Comments included, "I would tell my wife and she would complain for me" and "I'd tell the doctor if I had problems; I would complain if needed."

The service had a formal complaints policy and procedure. This described how complaints were dealt with. It covered timescales for acknowledging and investigating complaints and for keeping people informed. The procedure described how to escalate a complaint to other agencies should people remain unhappy with internal investigations.

We looked at the complaint file maintained by the registered manager of the service. This showed us the service received very few complaints and when issues were raised by patients or their relatives these were taken seriously and addressed promptly.

Staff spoken with were aware of the complaints procedure and where to locate information for patients who used the service. They told us they would support patients and their relatives to make a comment or complaint when they needed assistance. Comments included, "We don't get many complaints but we would investigate them" and "There is a booklet in each room about the service and it includes how to complain."

The registered manager held a file with cards of thanks and compliments about the service. We looked at a selection of comments and found these were very positive. They described staff as kind, caring and compassionate. They also commented on how staff respected privacy and dignity, and how they treated patients with affection.

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 other services less often. 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.

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. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). 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

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