Inspection Report

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

St Luke's Hospice

Little Common Lane, Whirlowdale, Sheffield, S11 9NE

Tel: 01142369911

Date of Inspection: 30 July 2013

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

Care and welfare of people who use services	✓ Met this standard
Meeting nutritional needs	✓ Met this standard
Safety, availability and suitability of equipment	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	St Lukes Hospice
Registered Manager	Ms. Judith Park
Overview of the service	St Luke's Hospice provides a range of specialist palliative care services for adults within a dedicated building offering 20 inpatient beds along with outpatient services. The hospice also has a community team who provide care and support for people and families in the home environment.
Type of service	Hospice services
Regulated activities	Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

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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 30 July 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information given to us by the provider and reviewed information sent to us by other authorities.

What people told us and what we found

We used informal observation to see how members of staff interacted with patients. We saw staff treated people with dignity and respect by using a positive, friendly and professional approach. We found people looked clean, tidy and had their medical, nursing and welfare needs met.

We talked with three patients and four relatives during our inspection. Patients told us they were happy with care at the hospice, liked all the staff who looked after them, thought the hospice was kept clean and they enjoyed their food. Some comments captured included "yes [the care] is very good ?excellent", "staff are very friendly", "the staff are brilliant", "nothing is too much trouble", "[I've] been spoilt and pampered" and "wonderful ? attend to all my needs."

Patients were supported to have adequate nutrition and hydration.

We found there were processes in place to ensure the safety, availability and suitability of equipment.

We found there were effective recruitment and retention processes in place.

We found people were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records had been maintained.

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

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

We used informal observation to see how members of staff interacted with patients. We saw staff treated people with dignity and respect by using a positive, friendly and professional approach. We found people looked clean, tidy and had their medical, nursing and welfare needs met.

We talked with three patients and four relatives during our inspection. Patients told us they were happy with care at the hospice, liked all the staff who looked after them, thought the hospice was kept clean and they enjoyed their food. Patient's confirmed that staff talked through care plans with them and kept them up date with aspects of their individualised care. Some comments captured included "yes [the care] is very good ?excellent", "staff are very friendly", "the staff are brilliant", "nothing is too much trouble", "[I've] been spoilt and pampered" and "wonderful ? attend to all my needs."

Since our last inspection in 2012 the original in-patient unit had closed and phase one of the new in-patient unit had opened. Considerable improvements had been made to the facilities available for patients in the new unit. These facilities included single spacious patient bedrooms which had a range of fittings designed to assist patient's personal needs. For example, each bed area included easy to reach controls for the wall mounted television, room lights, intercom based nurse call system and complimentary mobile telephone system. The room included space for a table and chairs which we found were useful for visiting relatives. Patient's told us they thought the bedrooms were "lovely" and one patient said "I can't fault this room it is great."

During our inspection we found the hospice employed a range of healthcare professionals to ensure people's care and welfare needs were met. These included palliative care consultants, medical staff, nurses and other members of the multi-disciplinary team including physiotherapists and social workers. The hospice used an evidenced based end of life care pathway and had a range of equipment, facilities and other services to meet the needs of people receiving palliative care. Care records demonstrated how the weekly multi-disciplinary team meeting strongly contributed toward the active development of

patient's individualised care whilst on the in-patient unit.

We reviewed a sample of six sets of care records. These included detailed medical and nursing admission and assessment documents, care plans, multi-disciplinary meeting records and other documents related to the care of the patient. We found care records, observation charts and risk assessment forms were completed to a good standard. The daily patient progress records were completed by all members of the multi-disciplinary team which allowed accurate and detailed contemporaneous records of each patient's daily care.

We talked with three staff nurses and one health care assistant from the in-patient unit. These staff told us they all worked well as a team and felt they were able to give quality care to patients who had been admitted to the unit. The staff thought their ability to ensure patient's privacy and dignity had significantly improved since the new in-patient unit had been opened. One staff nurse who had joined the unit five months ago said "I have never had such job satisfaction as I get here ? I feel I am able to give real quality nursing care."

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Patients were supported to have adequate nutrition and hydration. We talked with three patients and four relatives during our inspection. Patient's told us "food is good ?there is lots of choice", "food is brilliant", "lovely [food]" and "it's fantastic [food]." The last NHS 'patient led assessment of the care environment' (PLACE) visit by representatives of the local Healthwatch organisation was completed in June 2013. The 'patient assessment summary sheet' stated "the quality choice and service of food is excellent." We observed a lunchtime meal for day patients at the 'therapies and rehabilitation centre' and saw the service was delivered to a good standard.

We talked with the 'hotel services development manager' during our inspection who explained all food was freshly produced and locally sourced. We found there was a set menu available for breakfast, lunch and dinner based on a two week rota. The manager explained that these menus acted as a "guide" because patient's had complete choice on what they wished to order for each meal. Patients were also able to eat their meal when they chose and not at set times to ensure their individual preferences and needs were met. The menu also included a café type all day menu which was available to order from throughout the day. Various snacks and other options were made available through the night.

The deputy chief executive explained how the hospitality staff worked closely with the nursing staff. This included hospitality staff sharing information about the patient's preferences and food intake for each meal with the nursing staff. The hospitality staff also informed the nursing team when a meal was due to arrive to ensure a nurse was available to assist with feeding where this was required. All patients had a completed nutritional risk assessment and associated care plan. The nursing team maintained accurate records of people's daily hydration and nutritional intake.

Safety, availability and suitability of equipment ✓ Met this standard

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was meeting this standard.

People were protected from unsafe or unsuitable equipment.

Reasons for our judgement

We found there were processes in place to ensure the safety, availability and suitability of equipment. We reviewed the 'planned preventative maintenance plan' with the hotel services development manager and deputy chief executive. The plan showed at a glance all available types of equipment maintained within the hospice, including the frequency and date of servicing. Records showed the hospice utilised a range of external contractors to maintain and service specific types of equipment. For example, infusion pumps, syringe drivers and other medical type equipment had been regularly serviced by Sheffield Teaching Hospitals NHS Foundation Trust's 'medical equipment management service (MEMS).'

We found training had been delivered to members of staff where new equipment had been introduced. For example, the senior sister explained that a new infusion pump had been introduced earlier in the year. The manufacturer had delivered specialist training for all clinical staff required to use these pumps. The senior sister explained that the in-patient unit junior sister had been nominated as a trainer to continue delivering training for future newly employed clinical staff.

The hospice employed its own maintenance team. As part of their role they regularly serviced items, for example, cleaning and greasing wheels on wheelchairs and bedside tables. There were processes in place to report faulty equipment. We talked with three staff nurses and one health care assistant who told us faulty equipment was always promptly addressed and repaired. The staff also explained that suitable equipment was always available.

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.

Reasons for our judgement

There were effective recruitment and selection processes in place. We found the provider had recruitment policies and procedures. The human resources manager explained a number of new staff had been recruited within the last six months due to the phased re-development of the hospice (which required extra temporary staff). We reviewed a sample of six files of recently recruited members of staff. We found appropriate checks had been undertaken prior to employment, including application forms, identity checks, references, disclosure and barring (DBS) checks, qualifications and interview notes along with other information.

The human resources manager and senior sister explained how new members of staff were supported once they had commenced employment. The process included a probationary period and induction. New registered nurses also received a period of additional preceptorship support. We talked with two staff nurses who had recently been employed. They explained how they had found the hospice induction and preceptorship valuable and they felt they had been very well supported by managers and colleagues.

Records ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

During our inspection we found people were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records had been maintained.

The provider had policies, procedures and processes in place to ensure records were managed appropriately in relation to information governance and data protection guidance. For example, the deputy chief executive was the nominated 'caldicott guardian' who had recently undertaken specific updated training for this role. The hospice had recently completed a full 'information governance toolkit' assessment. We saw evidence which demonstrated staff regularly received training about data protection during their induction. The hospice had completed a draft leaflet 'the Data Protection Act and St Luke's Hospice' which outlined what members of staff needed to know and what they needed to do in relation to data protection.

We found each patient had a range of medical and nursing assessment documents, care plans, multi-disciplinary meeting records and other documents which had been maintained to a good standard. Entries by the nursing team in the daily progress records had been numerically cross referenced to each respective care plan. This meant patient's individual care for the day could be clearly identified in relation to their care plan.

We found a number of admission and assessment documents included the same assessment repeated by both the medical and nursing staff. The 'patient carer communication' record was no longer effective because they were no longer used by most members of staff. Communication with family and patients was recorded within other records such as the daily progress record. The senior sister explained how new care plans had recently been developed and introduced. The hospice had set up a new 'medical records group.' This group aimed to review, streamline and fully integrate the admission and assessment records within a defined timescale.

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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