Inspection Report

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

St Peter's Hospice

Charlton Road, Brentry, Bristol, BS10 6NL

Tel: 01179159400

Date of Inspection: 08 September 2013

Date of Publication: September 2013

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Meeting nutritional needs	✓ Met this standard
Cleanliness and infection control	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	St Peter's Hospice
Registered Manager	Ms. Julia Di Castiglione-Dawkins
Overview of the service	St Peter's Hospice is located in Bristol. They provide care to adults with life limiting illnesses, and their families. As well as caring for people as inpatients, the hospice provides a service to people in their own homes, a day hospice and a 24 hour support and advice service by telephone.
Type of service	Hospice services
Regulated activities	Diagnostic and screening procedures Nursing care Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury

Contents

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

Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 8 September 2013, 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

During our inspection we spoke with four people who were using the in patient service and five relatives of people who used services. People consented to their care and treatment and staff informed them of the effects and benefits of their treatment. One person said "staff tell me what every tablet they give me is and explains what the medication does". Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

People told us that they were pleased with the care and treatment they received. One person said "you can't fault the place, the staff are excellent and can't do enough for you".

People's needs were assessed and care plans developed to meet these needs were up to date.

People told us that the food at the hospice was very good and they were able to have their choice of food when they required it.

Systems were in place to ensure cleanliness and infection control was monitored effectively. People and visitors told us that the service was always very clean and tidy. We observed staff using personal protective equipment appropriately.

Staff told us they received regular training and support which allowed them to carry out their roles effectively.

The service had effective systems in place to monitor the quality of the service provided. This included gaining feedback from people who used the service and their relatives. We found that this feedback was monitored and acted on to improve the service.

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.
And
Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

People we spoke with told us that staff always informed them of what treatment or support they were going to provide before they commenced. One person told us that staff informed them of every medication they gave them and explained what the side effects may be and the positive and negative effects of the medication.

We saw from records that people had signed to say they consented to their treatment. People told us that they felt 'fully involved' in their care and treatment. We saw that staff had received training in the Mental Capacity Act 2005 (MCA). Staff we spoke with were clear about the MCA and described to us the process of making decisions for people in their best interest if they lacked capacity. This meant that where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Staff told us that when people lacked capacity to be involved in decisions about their care and treatment, they consulted the person's family. Relatives we spoke with confirmed that they felt included and involved in their relatives care. A relative of an individual being cared for told us that she felt "completely included" in her relative's care.

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.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We spoke with four people who received a service from the inpatient department. All the people we spoke with were very satisfied with the service they received from the hospice. Comments we received from people included: "you can't fault the place, the staff are excellent and can't do enough for you", "the continuity of the staff is excellent and they seem to pre-empt things before they happen" and "the staff speak to you as an individual and not as someone who is ill".

We looked at the records of five people. The service maintained paper records for people who were inpatients and transferred information onto an electronic records system. The records were up to date and care plans viewed reflected the care and support provided by the staff team. Staff we spoke with told us that the records system was very useful as it was used by community staff as well as staff at the inpatient unit. Staff told us that this allowed access to records relating to care and treatment the person had received in the community. They said this promoted consistency between the community and inpatient services.

Staff told us that multi-disciplinary working was really important. This was evidenced by people's records which showed that a range of health professionals were involved in people's care. For example, people had input from occupational therapists, physiotherapists, social workers, district nurses, doctors and complimentary therapists. We were told that multi-disciplinary meetings were held on a weekly basis to discuss people's care and treatment. This meant that people's care and treatment reflected guidance from a range of professionals.

Many of the people who were inpatients when we visited the service also received a service from the community team. People told us that the support they received from the community team was very good. We were told that the community team had access to the computer records and we were told that this was important for continuity of care.

We were told that the staff team was divided into two teams red and purple. People were allocated a team when they arrived at the service. Staff told us that this ensured continuity of staffing for people and allowed staff to gain a good knowledge and understanding of

people's needs.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. We saw that people's needs were assessed before they entered the service and during the first three days of admission to the service. From these assessments care plans were developed to ensure that the identified needs were met. All plans were person centred and reflected the person's needs and preferences. Examples included pain management, dietary preferences and spiritual beliefs.

We were shown risk assessments that encouraged independence and aimed to reduce people's anxieties. Staff told us that care plans and risk assessments were evaluated regularly every week or earlier if required. This was confirmed in the care records we viewed. The registered manager told us that all the people who were admitted to the service had a care plan for falls and mobility.

Staff we spoke with demonstrated a good knowledge and understanding of people's needs. They were able to tell us key information about people, including the reasons why they were referred to the service and how their needs were met. People we spoke with agreed staff knew them and how to care for them and what they liked or disliked. One relative we met said the staff "always had time to talk with them and answer any questions".

We saw that information on death, dying and bereavement that was available to people and their families. There were facilities available for relatives to stay so that people could have relatives with them at all times at the end of their lives. Staff explained that the service made every attempt to provide people with a death that was dignified, respectful, private and comfortable.

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

People we spoke with told us that they were able to choose their meals from a menu on the day they received the food. They all told us that there was flexibility and if you didn't want anything on the menu then an alternative would be provided. Comments we received from people included: "the food here is excellent, there is so much choice", "I don't eat a lot but if I ask the staff for something when I feel like eating, they get it for me" and "They are so flexible, if you want a sandwich at 2am it is not a problem".

People were protected from the risks of inadequate nutrition and dehydration. We saw from records that people were assessed in relation to nutrition and care plans developed to meet these needs. We saw that people had fluids within their reach and these were replenished throughout the day. We also observed staff and volunteers offering people and their visitor's drinks throughout our inspection. People were able to eat their meals in their rooms or in the dining room. We saw that equipment such as adapted cutlery, crockery and cups were available for people if needed.

People chose their meals from a menu which had a range of choices for people including a vegetarian option. Staff told us that if people didn't like any food on the menu then they would be asked what they would like as an alternative. This was confirmed by people we spoke with. We were told by the chef that all the meals provided were cooked from fresh. This meant people were provided with a choice of suitable and nutritious food and drink.

We spoke with the chef who told us that they have good communication with staff who worked at the service. They told us that they were informed of any dietary requirements that people had. This was displayed on a white board which we were told was updated on a daily basis. We saw that the information recorded on the whiteboard reflected the information we viewed in people's care records. This meant that the service had a system in place to ensure that people's dietary requirements were met.

At the time of our inspection there was no one using the inpatient service that had religious or cultural needs in relation to food. The chef told us that they were able to provide food that met with people's religious or cultural needs. They also told they would meet with that person to discuss what kind of food they liked and would be able to provide for such requests. We were told that the service had arrangements in place to provide halal meat if required. This meant that the service was able to provide food and drink that met with

people's religious or cultural needs.

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed.
And
People were cared for in a clean, hygienic environment.

Reasons for our judgement

People and visitors told us that the service was always very clean and tidy. People told us that staff washed their hand frequently and always wore gloves and aprons when providing personal care.

We observed that the environment appeared clean and tidy. The service had two sluice rooms which were at each end of the service. Bathrooms were clean and free from odours. All rooms had hand washing facilities and alcohol gel along with posters containing information on how to wash your hands properly. We observed staff washing their hands before and after providing support for people and wearing appropriate personal protective equipment. For example, disposable gloves and aprons. This meant there were effective systems in place to reduce the risk and spread of infection.

We saw that good practice in infection control was being implemented at the service. For example, qualified nursing staff had been assessed and had their competency assessed for providing certain invasive treatments using a 'non-touch' technique. This technique reduced the associated risks of infection which such treatments could pose. We were told that if people using the service required the use of a hoist the risk of infection was reduced by using a single use disposable sling.

We saw that infection control audits were carried out in the home. We viewed copies of these audits and saw that where areas of concern were identified actions were taken to address shortfalls. We were told that the service had a lead infection control nurse for the service.

There were effective systems in place to reduce the risk and spread of infection. Staff we spoke with told us that the home was kept clean and incidents were dealt with quickly and efficiently. We saw that staff wore personal protective equipment (PPE) such as disposable gloves and aprons appropriately. Staff were also aware of when to change their PPE and how to dispose of it appropriately to reduce the risk of cross infection.

We spoke with staff about the use of PPE. Staff demonstrated a good knowledge of when PPE was appropriate. For example, staff told us they were aware of the importance of changing PPE in between person and task, and when engaged in a higher risk task such as managing a person's catheter.

Staff received training in infection control measures and we saw from records that staff were up to date with this training. Staff we spoke with had a good knowledge of infection control procedures and were aware of the importance of infection control.

Supporting workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Staff we spoke with said they enjoyed working at the service. When we asked people in the service about the staff, one person told us "the staff here are excellent" and "staff and the doctors always explain things to me so that I can understand". All the staff we spoke with told us that they received good support and training to enable them to carry out their jobs effectively. They told us that they were able to seek support from their managers or other staff whenever they needed to and that debriefs were held when needed. Staff we spoke with told us that they received an annual appraisal in which they looked at how they could develop their skills over the year.

The team leader told us that they met with the ward manager on a one to one basis every month and also received clinical supervision. They told us that the clinical supervision was held with a group of staff working at the same level in different areas of the service. The team leader told us this enabled them to gain different perspectives on problems or issues they encountered and was very helpful.

We were told by the registered manager that all staff completed their mandatory training in subjects including: Back care, fire training, food hygiene, safeguarding adults and children, risk assessment, Mental Capacity Act, Health and Safety, Deprivation of Liberties Safeguards, Coshh and Information governance. This was confirmed by training records that we viewed during the inspection.

Staff we spoke with confirmed that they had received a comprehensive induction when they started working at the service and completed courses that were relevant to the service. The training available included supporting people in loss, grief and bereavement and communication with people in palliative care.

Staff told us that they were encouraged to enrol on courses relevant to the service they provided. For example one person was being funded to complete their masters in management. The registered manager told us that training and development of staff was important to the development of the service. We saw that staff had the opportunity to complete their diploma in health and social care. This meant that staff were able, from time to time, to obtain further relevant qualifications.

Staff told us how they put the knowledge into practice in their daily work with end of life care. They told us that they felt confident to carry out their roles and that the training helped them understand the needs of the people they cared for. We were shown records of training that occurred in 2012 and the plan for training in 2013 which confirmed these courses were presented regularly.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

We reviewed the systems that the service had in place for monitoring the service. We saw that a range of audits were carried out at the service and looked at areas that were linked to the essential standards of quality and safety. These included audits on infection control, symptom control, documentation, policies and procedures, response times to referrals and prescribing practices for medications. The service ran an audit group in which the results for these audits were presented and discussed by staff working at the home. Recommendations were then made to the clinical governance group for approval and implementation.

We were told that the inpatient service commissioned an independent review of their service. This was carried out by another provider of hospice services and a report produced. We saw that the service had developed an action plan to implement the recommendations of the report. We viewed the resulting action plan and saw that the actions were being implemented and monitored by the registered manager. The registered manager told us that it was important that the service learnt from other providers and best practice in the field to enable them to develop the service.

People who used the service were asked for their views about their care and treatment and they were acted on. The service used volunteers to speak to people on a weekly basis to gain an insight into patient experience. The manager told us that volunteers were used to ensure that there was an element of independence in the process. We also saw that questionnaires entitled 'your opinion matters' were available in the service for people and their relatives to complete. We saw that feedback was very positive and the results were analysed and actions taken to ensure shortfalls were addressed.

Clinical governance meetings were held every three months at the service. These looked at the implementation and review of policies and procedures as well as discussions on relevant clinical issues. We viewed the minutes of these meetings which showed that where deficiencies were identified, actions were taken to ensure that standards were raised.

During our inspection we saw that incident and accident forms were monitored by the service. This was confirmed by looking at records. We saw that incidents were investigated by senior staff and that actions were taken where appropriate to ensure that incidents and accidents were less likely to occur in future.

The registered manager told us that the hospice had regular meetings to discuss and evaluate people's care and treatment. This meeting was attended by staff at all levels of the service and was used to identify good practice and look at areas where they could have done things better. We also saw that appropriate incidents were reported to the relevant authorities such as the Care Quality Commission. This meant that there was evidence that learning from incidents / investigations took place and appropriate changes were implemented.

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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