Care Quality Commission

# Inspection Report

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

## Wakefield Hospice

Aberford Road, Wakefield, WF1 4TS

Tel: 01924213900

Date of Inspection: 19 September 2013

Date of Publication: October 2013

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

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|---|---|
| **Respecting and involving people who use services** | ✓ Met this standard |
| **Care and welfare of people who use services** | ✓ Met this standard |
| **Cooperating with other providers** | ✓ Met this standard |
| **Requirements relating to workers** | ✓ Met this standard |
| **Records** | ✓ Met this standard |

## Details about this location

| | |
|---|---|
| Registered Provider | Wakefield Hospice Company |
| Registered Manager | Ms. Karen Crawshaw |
| Overview of the service | Wakefield Hospice is part of the Wakefield District specialist palliative care network. It provides specialist palliative care in regard to symptom control, respite and terminal care for people with life limiting illnesses such as cancer and other progressive illnesses. |
| Type of service | Hospice services |
| Regulated activities | Diagnostic and screening procedures<br>Transport services, triage and medical advice provided remotely<br>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 19 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

At the time of our inspection there were seven people using the service. We spoke with two people and four of their visitors to gain their views of the service. People told us all the staff communicated with them well so they understood the care and treatment choices available to them. One person explained: "The staff talk to us about my care and give us options. We can ask questions and the staff explain things." A visiting relative told us: "The care here is good. I have no worries and nothing negative to report."

We spoke with the Registered Manager and five staff members from a variety of roles working within the hospice about the care and treatment of people who used the service. All staff had a good understanding of the importance of promoting people's independence, and recognising and respecting people's individuality. They spoke knowledgeably about the needs of the people in their care. Staff told us they worked well together as a team.

We reviewed four people's care records which documented multi-disciplinary discussions and communication with other agencies, such as people's GP, hospital consultants, community based specialist nurses and social workers. We saw the records were fit for purpose and contained accurate assessments of people's needs.

We saw people's care records, staff files and other key documents were stored securely and could be located promptly by staff when 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

**Respecting and involving people who use services** ✓ Met this standard

**People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run**

### Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

### Reasons for our judgement

At the time of our inspection there were seven people using the service. We spoke with two people and four of their visitors to gain their views of the service. People told us all the staff communicated with them well so they understood the care and treatment choices available to them. They said they had been able to express their views and had been involved in making decisions about their care and treatment. One person explained: "The staff talk to us about my care and give us options. We can ask questions and the staff explain things." A visiting relative told us: "The staff treat my relative well, and they are very respectful."

We spoke with the Registered Manager and five members of multi-disciplinary staff team. The staff had a good understanding of the importance of promoting people's independence, and recognising and respecting people's individuality. For example, at the time of the inspection, one person was celebrating a relative's birthday. The person's family had come to visit and had decorated the room with banners. Staff were respectful of this and gave the person private time with their family.

Staff explained how from admission and throughout their stay in the Hospice, assessment and care planning was based on the person's expressed needs and priorities as they perceived them. Staff explained how they encouraged people to express their views and supported them in making decisions about their treatment and care. They described how they maintained people's privacy and dignity and independence as far as possible.

We reviewed four people's care records which confirmed people who used the service and/or their representatives were involved in making decisions about their care and treatment. Where there was uncertainty about people's capacity to make decisions, a mental capacity assessment was carried out and decisions made in people's best interests involving relevant specialists, family members and advocates where appropriate.

**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

During our inspection we spoke with two people who were using the service and four of their visitors about their experience of the care and treatment they received at the Hospice. All were complimentary about the level of care. One person told us: "The staff are very good. They treat me very well and always sort things out for me." Another person commented: "It's perfect." A visiting relative explained: "The care here is good. I have no worries and nothing negative to report."

We reviewed four people's care records and found they were comprehensive, clearly written and maintained to a good standard. We saw evidence of discussions of people's involvement in the planning of their care and treatment. The records also contained information about multi-disciplinary team meetings and discharge planning. This provided ease of access to all the person's care, treatment and support information to meet their individual needs in one place.

The care records we looked at contained assessment information in areas such as nutrition, pressure area care and falls risk. We saw some information about how to manage the falls risk had been recorded on the risk assessment form, and other information in the daily communications section of the care records. However, we found there were no specific care plans in place to clearly identify how the falls risk should be managed to meet the person's individual circumstances. This is dealt with under outcome 21 later in the report. We spoke with nursing staff specifically about falls risk assessment and management. They were able to identify people who were at high risk of falling, and were able to describe how the risk was managed for each individual. This showed care was planned and delivered in a way that was intended to ensure people's safety and welfare

People using the service received care from a multi-disciplinary team consisting of doctors, nurses, therapists, social workers and healthcare support workers. We spoke with the Registered Manager and five staff members from a variety of roles working within the hospice about the care and treatment of people who used the service. All staff spoke knowledgeably about the needs of the people in their care. They were able to describe the reasons why people had been admitted into their care, and to describe what their wishes were for their treatment and care. Staff told us they worked well together as a team.

**Cooperating with other providers** ✓ Met this standard

**People should get safe and coordinated care when they move between different services**

## Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

## Reasons for our judgement

People we spoke with told us staff were knowledgeable about their health condition before they were admitted as they had obtained information from other agencies such as the hospital specialist and their GP. They also confirmed the Hospice communicated well with other agencies about their care and treatment and to support their discharge home.

We spoke with the Registered Manager and five members of multi-disciplinary staff team. They described how they had good working relationships with other agencies and worked in co-operation with others to provide appropriate care to meet people's needs. They described how they worked together as a multi-disciplinary team within the Hospice. They told us they also had good access to specialists from other agencies where it was appropriate to meet the needs of the individual, such as the local acute hospital Trust, GP practices, community nursing, therapy and social services. They described how they pro-actively sought involvement from relevant agencies in assessment, care planning and discharge planning to meet each person's individual needs. This showed people's health, safety and welfare was protected when they moved between different services.

We reviewed four people's care records which documented multi-disciplinary discussions and communication with other agencies, such as people's GP, hospital consultants, community based specialist nurses and social workers. We saw evidence in the care records which confirmed the Hospice pro-actively involved community based services in discharge planning to ensure the person received appropriate care and treatment when they returned home.

**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

We spoke with the Registered Manager who told us all new staff had appropriate checks as part of their recruitment before working for the service. We saw there was a policy in place which was in the process of being updated to reflect the changes in national policy requirements, including the change to the Disclosure and Barring Service (DBS) checks, formally known as Criminal Record Bureau (CRB) checks.

We spoke with five members of staff who confirmed recruitment processes had been followed and appropriate checks had been carried out prior to them joining the service. Staff confirmed they had completed induction training and felt suitably skilled and supported to carry out their work safely.

We reviewed a sample of five staff records and found appropriate checks had been undertaken before staff began work. We saw they contained the necessary documentation to show recruitment procedures were being followed to protect people who used the service from unsuitable workers. All the staff files reviewed contained copies of application forms, interview notes and proof of identity. All of the records contained appropriate references.

We saw evidence of recent CRB clearance checks in four of the five records we looked at, but could not find evidence of a recent CRB check for one staff member who had worked for the service for a number of years. We spoke with the administration staff about this. They demonstrated how electronic records were maintained and prompted annual reviews of DBS/CRB and professional registration checks. However, the provider may find it useful to note that on reviewing the system it was acknowledged there was no record of a recent CRB/DBS check for this one staff member. We saw evidence that checks had been completed for all other staff working in the service. An application form for a DBS check was given to the staff member for completion and submission during the inspection.

**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

We saw people's care records were stored securely within an office which was locked when not in use. Care records could be located promptly by staff when required. We looked in detail at four people's care records. We saw the records were fit for purpose and contained accurate assessments of people's needs. This included risk assessments for areas such as nutrition, tissue viability and falls. We saw three of the people whose records we reviewed were identified as being at high risk of falls. The provider may find it useful to note there were no specific care plans in place to clearly identify how the falls risk should be managed to meet the person's individual circumstances. People's risk of falling may be increased if staff do not have easy access to a clear and concise plan of action to take to keep the person safe from falling.

We saw staff files were stored securely. We looked in detail at five staff records. We saw some information was maintained in a paper format, and other information was held electronically. Staff records and other records relevant to the management of the service were accurate and fit for purpose.

We saw there were policies and procedures in place regarding the management and archiving of people's care records, staff records and other key documents. We looked at the processes in place for filing and archiving care records and other significant documentation. The system looked well organised and easy to follow making the process easy for staff to manage effectively. Archive storage of records was done through an external contractor which included their safe, secure destruction after the appropriate period of time. This meant the provider had taken appropriate steps to protect people's records.

## 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.

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| ✓ **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.<br>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.<br>We monitor the implementation of action plans in these reports and, if necessary, take further action.<br>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:

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|---|
| 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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