

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

St Mary's Hospice Limited

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Date of Inspection: 31 January 2014

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2014

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
Staffing	✓	Met this standard
Supporting workers	✓	Met this standard
Statement of purpose	✓	Met this standard
Assessing and monitoring the quality of service provision	✓	Met this standard

Details about this location

Registered Provider	St Marys Hospice Limited
Registered Managers	Mr. Dafydd Lloyd Edwards Ms. Tina Swani
Overview of the service	Birmingham St Mary's Hospice provides nursing and personal care, diagnosis and treatment for people over eighteen years with a terminal illness. It may accommodate up to 25 people and also provides treatment through a day service and a community service.
Type of services	Community healthcare service Domiciliary care service Hospice services
Regulated activities	Diagnostic and screening procedures Nursing care Personal 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'.

	Page
<hr/>	
Summary of this inspection:	
Why we carried out this inspection	4
How we carried out this inspection	4
What people told us and what we found	4
More information about the provider	5
<hr/>	
Our judgements for each standard inspected:	
Care and welfare of people who use services	6
Staffing	8
Supporting workers	9
Statement of purpose	10
Assessing and monitoring the quality of service provision	11
<hr/>	
About CQC Inspections	12
<hr/>	
How we define our judgements	13
<hr/>	
Glossary of terms we use in this report	15
<hr/>	
Contact us	17

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 31 January 2014, checked how people were cared for at each stage of their treatment and care and talked with carers and / or family members. We talked with staff.

What people told us and what we found

We inspected the service that was provided in people's own homes, the Hospice at Home service. At the time of our visit there were five people receiving this service but over one hundred and fifty people had used it over the past 12 months.

We found that people's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. Nurses and nursing assistants from the service worked with District Nurses from the NHS Community Healthcare Trust to provide end of life care for people in their own homes.

There were sufficient numbers of staff on duty to meet people's needs. The service was staffed by Registered Nurses and nursing assistants who were supported by a manager and an administrator. The service also had flexible staffing arrangements to meet demands and people's changing needs. Staff were properly trained, supervised and appraised. They received support to deal with the challenging nature of their work providing end of life care in people's homes.

Information about the safety and quality of service that people received was gathered and scrutinised and used to improve the service. This included gathering the views of people who used the service and of other stakeholders in the service such as district nursing teams.

A family member of a person who used the service told us, "My [relative] likes them, they are very thorough and very caring...I don't know what we would do without them, they have been great."

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 benefited from appropriate arrangements to assess their needs and plan, provide and regularly review care that met their needs and protected their rights

Reasons for our judgement

When we visited St Mary's Hospice on 31 January 2014 we inspected only the part of the service that was provided in people's own homes, the Hospice at Home service. At the time of our visit there were five people receiving this service. The manager told us that over the past 12 months over one hundred and fifty people had received the service.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We looked at the care files of five people that were kept at the Hospice at Home office at Birmingham St Mary's Hospice. We noted that each file included key information about the person including contact details for next of kin, social workers and their GP. There were referral documents that included an integrated multi-disciplinary referral form and nursing transfer letters. Files contained health and diagnosis information, a 'quick glance' patient summary that included reference to consultant involvement with the person's plan. There was also an outline of the support needs of the person's primary carer such as spouse, relative or friend. We noted that staff visited the person and carried out an assessment of their needs at home. Each file contained a statement of the outcome of the person's needs assessment. This confirmed that as they had expressed their wish to be cared for to the end of their life at home, the Hospice at Home service was appropriate to meet their needs at that time.

Risks presented by the person's needs and by the environment of their home were assessed. We saw notes in each file of the ongoing evaluation of the person's healthcare needs, these were clearly written, informative and signed by nurses and nursing assistants/health care assistants.

The manager told us that nurses and nursing assistants/health care assistants from the service worked with district nurses from the NHS Community Healthcare Trust to provide end of life care for people in their own homes. Nursing assistants/healthcare assistants that we spoke with confirmed that they provided personal care to people alongside the nursing care that they received. They told us that they were able to spend

time with people and to support them with personal care at the person's own pace. Visits to people were planned within time bands each day and this allowed Hospice at Home staff to respond flexibly to each person's specific needs on each day. Staff told us "This is a very necessary service. We visited a person for personal care this morning and had time to do it at the pace of the patient which, district nurses don't always have time to do, for example giving the person a wash and shave."; "We can be responsive including the times of our visits, for example if a person has had a restless night we can go to them early and spend time with their families."; "We can give time. Relatives will want to talk about how the night went and how things are and that takes time."

A family member of one person who was receiving a service from Hospice at Home was willing to speak with us at the time of our inspection. They confirmed that there was a written plan of care and other records kept at their relatives home. They said that as their relative's needs had changed when they came home from the Hospice, there was a re-assessment in progress. They told us that regular records were made by District Nurses and also by Hospice at Home nurses and health care assistants. They confirmed that Hospice at Home staff worked together with District Nurses to care for the person and support their family. They told us "They do a great job, they really do...they do turn up roughly when expected and we have never been let down, they came back twice in one day once [because we needed it]...I don't know what we would do without them, they have been great."

We noted that all five of the people who were receiving the service at the time of our inspection were white European males. The manager told us that the service had been provided to a more diverse range of people through the preceding year and we saw that information was collected for gender, ethnic origin and sexual orientation. She told us that Birmingham St Mary's Hospice was however taking advice on how it could better convey its intention to be inclusive although its name carried a particular religious identity.

Staffing

✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

People had their health and welfare needs met by sufficient numbers of appropriate staff.

Reasons for our judgement

There were sufficient numbers of staff on duty to meet people's needs. The manager told us that the service was staffed by Registered Nurses and health care assistants/nursing assistants. At the time of our inspection there were five people using the Hospice at Home service. The Hospice at Home service employed three nursing sisters and three nursing assistants/health care assistants. Nursing and healthcare assistants held vocational qualifications in Health and Social Care and attended annual study days for end of life care. This meant that they kept up to date with the knowledge and skills needed to carry out their role. The team was managed by a Lead Nurse and supported by an administrator.

The service also kept a 'bank' of staff to call on if numbers of people or people's needs increased significantly. The nature of the service provided meant that the numbers of people using it at any one time could vary very quickly. This meant that the service had flexible staffing arrangements to meet demands and people's needs. We saw the caseload management sheet for the day of our visit and noted that staff were allocated to visit each person who used the service. A family member of one person confirmed that two workers had visited together, as arranged, to support her relative on the morning that we spoke with them.

There were sufficient staff who knew people's needs. We spoke with four staff including nurses and health care assistants/assistant nurses. They were able to describe the needs of people who used the service at that time and the agreed plans to meet those needs. A family member told us "My [relative] likes them, they are very thorough and very caring."

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 are safe and their health and welfare needs are met by competent staff.

Reasons for our judgement

We spoke with four staff on the day of our visit. They included registered nurses and nursing assistants/health care assistants. The nursing assistants and health care assistants performed the same role and they supported people with their personal care.

Staff were properly trained, supervised and appraised. Managers told us that nursing assistants/health care assistants were supervised by a registered nurse and they had regular one to one meeting to discuss their work. This was confirmed by the assistants that we spoke with. Registered Nurses described the peer support that they received from each other within the team and monthly one to one meetings with the Lead Nurse who managed the team. All staff had an annual performance and development review and appraisal.

Staff were properly supported to provide care and treatment to people. The team held monthly meetings and they described to us the daily contact and support that could expect from each other. They told us that they also had personal access to the social work and bereavement teams in the Hospice. This helped them to deal with the challenging nature of their work providing end of life care in people's homes. All staff that we spoke with told us that they felt confident about discussing difficulties with peers or managers. This indicated an open culture within the service. The provider had a lone working policy and set of procedures to protect staff working in the community.

Staff that were recently appointed told us that they had an induction programme. We noted the content of the programme in a training file and it covered a range of relevant topics and appropriate skills for the role that they performed within the team. Staff told us that they attended a rolling programme of mandatory training to keep up to date with health and safety issues and other relevant topics such as safeguarding and equality and diversity. Staff also told us that they had access to professional training courses and events and were supported to attend them.

Statement of purpose

✓ Met this standard

The service must tell us about what kinds of services it provides

Our judgement

The provider was meeting this standard.

People that use the service benefit from the knowledge that the Care Quality Commission is informed of the service being provided.

Reasons for our judgement

The provider had a statement of purpose for the service that set out what it offered. This was kept under review and a recently updated copy given to the Care Quality Commission. The services that were offered included the 'Hospice at Home' service and clearly set out its aim. We noted that the service being delivered to people was consistent with what the statement of purpose offered.

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

Information about the safety and quality of service that people received was gathered and scrutinised. We saw from evaluation forms that had been sent to eleven community District Nurses teams around south Birmingham during 2013 that the service sought feedback on whether it was meeting people's needs. The responses were generally positive. The manager told us that a further survey was being undertaken at the time of our inspection. Operational meetings were also held between St Mary's Hospice and the community teams to get their feedback. We saw that, as Hospice at Home was a new service the manager had produced quarterly reports during 2013/14 from information gathered to assess its progress, quality and efficiency against its stated aims. The provider may find it useful to note that some quality monitoring mechanisms remained to be developed in this new service, to identify, assess and manage risks related to providing care to people at home. For example there was no clear system in place to check the quality of care from records made by staff in people's homes. There was no system to gather together information on the up to date status of training within the team for planning purposes.

People who used the service, their representatives were asked for their views about their care and treatment and they were acted on. We saw completed patient/care satisfaction evaluation forms and noted that this feedback that had been collected as people used the service, during 2013. The responses were generally very positive. We spoke with the family member of one person who used the service at the time of our inspection and they told us, "They do listen to our views."

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.

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