

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

176 Raddlebarn Road, Selly Park, Birmingham,
B29 7DA

Tel: 01214721191

Date of Inspection: 27 February 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
Safeguarding people who use services from abuse	✓ Met this standard
Staffing	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	St Marys Hospice Limited
Registered Managers	Mrs. Patricia Castanheira 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 health care services - Nurses Agency only 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

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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 27 February 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

People's needs were assessed and care and treatment was planned and delivered in line with their care plans. People told us they were clear about the aims of care and treatment and they were very positive about their experience of the service. Before people received any care or treatment they were asked for their consent and we saw regular accounts of verbal consent from day by day discussions between people and staff in people's records. One person said, "It's very good here, very well run. If I wanted to I couldn't find anything to complain about."

There was written policy and procedures for recognising and responding to abuse of vulnerable people. People said they felt safe at the service and staff said there was an 'open culture' in which staff could raise any concerns and managers would act on them.

There were sufficient numbers of staff on duty to meet people's needs and people told us that there was always someone available when they needed them. People said that staff were competent and took time to listen to them. We found that the service was well supported with medical, care and ancillary staff and also volunteer workers.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained. We found that people's medical and care records were up to date and kept securely. Records necessary for the safe running of the service and the building were also up to date.

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.

People who used the service benefitted from suitable arrangements for obtaining, and acting in accordance with, their consent in relation to the care and treatment provided for them.

Reasons for our judgement

We specifically focused on the care of three people who used the service including one person who used the 'day hospice' service. Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

We saw regular accounts of verbal consent as a result of day by day discussions between people and medical care staff in people's records. These ranged from a person's preference to stay in a single or shared room, to changes in medication, contact with physiotherapists, 'do not resuscitate' requests and discharge planning. People told us that medical and care staff at the service always took time to explain the options for their treatment and care. One person said, "Yes, they always ask for my consent, for everything, all along the way". Relatives that we spoke to told us that they had also been involved in deciding and agreeing discharge plans of care for their family member.

We spoke with managers, nurses, health care assistants and doctors and they all described an approach to caring for people that used their service that was 'patient led'.

A new member of the medical staff told us that, compared with other health services in which they had worked it was their opinion that St Mary's was very good at addressing consent.

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

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. People that we spoke to told us that they were clear about the aims of their admission, plans for their discharge or their attendance at the day hospice service. We saw assessments that addressed a range of needs including risks presented by the person's condition, the level of insight a person had into their conditions, the impact on their family and their future expectations.

Updated action care plans were on record for each of the people whose care we specifically focused on. Medical staff told us that they agreed what were priority concerns for people throughout their contact with the service and made a plan for treating or supporting the person accordingly. We saw that inpatient plans were reviewed with medical staff on a daily ward round and action plans for day hospice care and support were updated weekly.

People and their relatives that we spoke to knew that there was a clear plan for their care and support and were very positive about their experience of the service. One person told us, "It's very good here, very well run. If I wanted to I couldn't find anything to complain about." Another person said that they had felt 'cut adrift' after their GP told them that no further treatment could be offered for their condition, but St Mary's had been able to plan and provide regular day hospice contact and care for them.

Medical and care assistant staff that we spoke with knew people well and their agreed plan of treatment and support. One nurse told us "I came into nursing to nurse and I get the time to do that here." Other staff at all levels and roles in the service commented that they were encouraged to take time to have good communication with people to better understand people's personal values and how these affected their needs.

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People were protected from abuse, or the risk of abuse and their human rights were respected and upheld.

Reasons for our judgement

Action is taken to identify and prevent abuse from happening in the service. People that we spoke to told us that they felt safe and well looked after at the service.

The service had a written policy and procedure that was in line with local multi agency agreements for recognising and responding to abuse of vulnerable people. Nursing and care staff that we spoke with were clear about their responsibility to report any concerns that they had about people's welfare. They told us they were confident that they would be listened to by senior managers and action would be taken. They said that the service had an 'open culture' in which staff could raise concerns without fear. A volunteer worker told us, "Everyone here cares about the patients including the ancillary staff. The patient's needs come first even if it's just to get the battery in their TV remote control changed without delay."

Wards managers gave us examples of how they had managed a person's care and supervision to reduce a risk of self harm or behaviour that had a negative impact on others using the service.

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. People told us that there were sufficient staff to look after them well and there was always someone there when they needed them. One person told us "They all work together- they move around each other and know what each other is doing." Another person told us that doctors, nurses and health care assistants listen to them and give them time to talk.

On the day of our visit we saw that the ward and the day hospice service were staffed with doctors, nurses and health care assistants. Managers told us that the ward was divided into two teams and that staffing levels were worked out to match patient needs over four shifts each day. A doctor was responsible for each team and the medical team was supported by consultants, GP's, specialist doctors and senior doctors. There was a nurse designated on shift for discharge planning each day to ensure that people left the service and returned to their homes safely and with the right level of support. We noted that the service was supported by administration, reception and housekeeping staff and volunteer workers. Volunteers included helpers who worked in the day hospice and on the ward in the evenings to support social care and help people with complex needs to eat and drink.

Managers told us that nurses were recruited with or encouraged to subsequently enrol in palliative care qualifications and health care assistants held National Vocational Qualifications in health and social care at level two or level three. A doctor new to the service told us, "Staffing levels are very good here and it's the best care that I have ever seen." People who used the service and their relatives told us that the staff were competent and they knew what they were doing.

One member of staff told us, "They get agency staff cover as soon as there is a gap so the staffing levels are always right, we don't have to stretch." A ward manager told us that regular agency staff were used to cover for any long term absence and also when newly qualified nurses were starting work to support the team for duties that required two nurses such as administering people's medication safely.

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

People's personal records including medical records were accurate and fit for purpose. We found that care records including daily journal records were in good order and up to date and stored securely to protect confidentiality. Nursing and care staff were given written information to about the welfare each person at the handover of their shift and we saw that they kept this sheet of paper in their pocket. There was a procedure for safely destroying this record as they left the ward.

We looked at a sample of records relevant to the management of the services including the safety of the environment and equipment such as the passenger lift, the fire risk assessment and the electrical installations. We found that records were up to date and could be located when we asked for them. Information about staff training was kept in good order and up to date.

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 dentists and other services at least once every two years. 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 but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. 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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