Inspection Report

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

Warwick Myton Hospice

Myton Park, Myton Lane, Warwick, CV34 6PX

Tel: 01926492518

Date of Inspection: 16 September 2013

Date of Publication: October 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
Cleanliness and infection control	✓ Met this standard
Supporting workers	✓ Met this standard
Complaints	✓ Met this standard
Records	✗ Action needed

Details about this location

Registered Provider	Myton Hamlet Hospice Management Limited
Registered Manager	Mrs. Karen Elizabeth Pedley
Overview of the service	Warwick Myton Hospice provides support to people with life limiting illnesses. The hospice provides inpatient and day services to patients, carers and their family members in Warwickshire and Coventry areas.
Type of 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'.

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 16 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, talked with staff and talked with local groups of people in the community or voluntary sector.

What people told us and what we found

When we visited Warwick Myton Hospice, we saw there were 19 people using the inpatient service. We spoke with two people who used the service and one relative. We spoke with the registered manager, the director of nursing and the provider's compliance and audit manager. We spoke with six members of staff delivering care, including a doctor, a deputy sister, a senior staff nurse, two staff nurses and a nursing assistant. We also spoke with the housekeeper and a senior chef.

We read the care records for three people who used the service. Many of the people were not able to tell us about their care because of their complex needs, so we observed care practice and staff's interaction with people when they were delivering care.

During our last inspection of this service in January 2013, we found the provider did not always maintain accurate and appropriate records. During this inspection, we found that some improvements had been made, however there were still areas of concern regarding incomplete records.

We looked at the cleanliness of the service and found that everywhere was clean and tidy. Staff we spoke with explained how they minimised the risk of infection within the setting.

We found that there was an effective procedure in place for recording and resolving any complaints about the service.

When we asked one person about the service they told us, "The staff are 11 out of 10, the care is excellent, I can't fault them."

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 02 November 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

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.

Reasons for our judgement

We looked at the care records for three people and found that there were no specific consent forms to indicate if people agreed to the care and treatment they were receiving. We looked at the information the provider gave people when they were first admitted and saw that it stated, 'Before a health care professional examines or treats you they will need your consent.' It went on to say that verbal agreement was usually sufficient, however for 'Certain procedures' written consent was required. We spoke with a doctor about when written consent was required and they told us that they asked people to sign written consents for invasive medical treatments. They told us that they discussed the benefits and risks of the procedure with people before they asked them to sign a consent form.

On the day of our inspection we observed that staff asked people's permission before they provided them with care and treatment. People we spoke with who used the service told us that staff asked for their consent before they helped them. One person told us, "They always gain permission before they help me." This meant that before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

We asked the doctor if people's capacity to make decisions was assessed. The doctor told us that if this was required it would be documented on the advance care planning document. The provider may wish to note that we looked at one person's advance care planning document and this was not completed. This meant the person's ability to make decisions had not been recorded.

We saw in people's care records that there were documents relating to future decisions about resuscitation in the event of a medical emergency. The provider may wish to note that on one person's form we saw that the recorded decision had not been discussed with the person or their relatives. The form stated, 'Discussed with relatives – no.' There was no record in the comments section to explain the reason why. We discussed this with the doctor who told us that in some cases there were no options for people and this would be

a harmful discussion to have with a patient. This meant that the documents relating to future decisions had not been fully completed.

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 two people who used the service and one relative. We asked them about their experience of using the service. Everyone we spoke with were positive about the care they received. One person told us, "The staff are friendly and very kind, I have everything I want." A relative told us, "It's so reassuring to have informed staff to talk to whatever time of day it is including weekends."

We looked at the care records for three people who used the service. We pathway tracked the care of two of these people. Pathway tracking meant that we followed people's experiences and checked to see that changes in their personal care or welfare needs were recorded. We found that the care provided to people was reflected in their care records.

We spoke to people about the care and treatment they received. One person told us, "I haven't signed any plans of care or anything". People we spoke with told us they were happy with the care they were receiving. We spoke with staff about how people contributed to their care records. They told us that when people first came to the service there was a meeting which included the person, their relatives if appropriate and a member of the nursing and the medical team. People were asked for information about themselves at the meeting and this would be documented in their care records in the relevant places by staff. Staff told us that they did not ask people to sign or review their records because it may not have been appropriate due to their health issues.

The care plans we saw included a lot of information. We found that care records were written on new documents which had been introduced during July 2013. The records included a patient assessment which was completed prior to people being admitted to the service, a nursing assessment which included people's care plans and risk assessments and an advanced care planning document to record decisions made by people in advance about end of life care. The provider may wish to note that some documents in the care records we looked at were not fully completed. There were some gaps in the records and some care plans had not been evaluated to see if they were up to date.

The relative of one person who used the service told us that, "The staff and doctors are very responsive. X was very sick following antibiotic therapy, she was quickly changed over within a couple of hours and her sickness settled." We found in the care plans we

looked at that they contained a review and evaluation section, however these sections often had nothing recorded in them. We spoke with staff about how they knew if people's needs had changed. They told us that they recorded any changes in people's daily notes and looked at the notes when they cared for people. We saw that daily notes were kept up to date by the nursing staff for each person.

We saw that some risks to people's wellbeing had been identified in their care plans. On one person's records we saw that a falls prevention screening tool had been completed and identified that this person required a more in depth assessment. We saw later in this person's records that a falls care plan had been completed to provide staff with information about how to minimise the risk of falls for this person. This showed that people's needs were assessed and care was planned and delivered in a way that was intended to ensure people's safety and welfare.

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. People were cared for in a clean, hygienic environment.

Reasons for our judgement

We found the provider had followed the Department of Health Code of Practice for cleanliness and infection control. The provider had a detailed and up to date policy for the prevention and control of infection. They had implemented a system to reduce the risk and spread of infection. The system included designated housekeeping staff that were responsible for cleaning and laundry, training and guidance for all staff, a cleaning schedule and provision of appropriate equipment and supplies. We saw on the provider's training matrix that 96 per cent of staff had completed training in infection control in the last 12 months.

We spoke with the housekeeping manager who showed us the cleaning schedules and the cleaning equipment. We saw that appropriate cleaning equipment and supplies were maintained. The housekeeper explained the use of colour coded equipment, for example red for bathroom areas, blue for general cleaning and green for the laundry. They told us that they conducted checks on cleanliness after domestic staff had cleaned.

We took a tour of the service on the day of our inspection and found that everywhere was clean and tidy. We found that bathrooms and toilets were clean and had good supplies for hand washing.

We looked at the laundry room and found that it was clean and tidy. Staff in the laundry explained the laundry process to us. There was a designated clean area and a dirty area. They told us how they kept soiled washing separate in appropriate laundry bags.

We looked in the kitchen and the senior chef told us that kitchen staff did their own cleaning. They showed us their cleaning schedules, which were clear and had been fully completed to record that cleaning tasks had been done. We saw that the area was clean and tidy.

The registered manager provided us with a copy of an infection control audit carried out by an infection control nurse from the local NHS Trust in February 2013. The overall score was 97 per cent compliant and actions had been identified to make improvements. This meant there was a process in place to check the cleanliness of the service.

During our visit we observed staff delivering care and saw that they used appropriate personal protective equipment, such as gloves and aprons.

We asked staff to explain how they would care for someone with an infectious disease. Staff told us that they transferred and washed people's laundry separately and used gloves and aprons to minimise the spread of infection. Domestic staff told us that they kept separate cleaning equipment for use in people's room, if they had an infectious disease.

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

During our visit we saw that there were systems in place which ensured staff had the skills and knowledge necessary to deliver care to the people who used day services and the domiciliary service. We spoke with six staff delivering care, we looked at five staff records and staff training records.

Training records showed when staff had undertaken training, which meant that the registered manager knew the skill and knowledge status of the staff who delivered care. Staff told us that they received a written request from the provider to attend training. The registered manager told us that ward managers were responsible for ensuring that staff's training was up to date. We saw that refresher courses for mandatory training had been planned.

The registered manager explained to us that there was an induction training programme for all new staff which included all the mandatory training. Inductions lasted approximately two weeks and staff were assigned a mentor for that time. The ward sister was responsible for new staff's drug competency assessments.

We spoke with staff about training. One member of staff told us they had been able to request additional training on palliative and supportive care and this had been planned for them. Another member of staff told us that the provider had supported them to complete their degree. This meant that staff were able to obtain further relevant qualifications.

We saw that there were 'Link nurses' in particular areas, such as tissue viability. This meant that staff could approach link nurses for information on their particular subject and they could give advice.

The provider may find it useful to note that some staff told us they did not feel appropriately trained in some chronic diseases such as Parkinson's disease. They told us that specialist advice was available from community advisors and link nurses, however they would value further training. We discussed this issue with the registered manager who told us that they would speak to staff about it and obtain their views.

Staff we spoke with told us that they were well supported by their managers. One member

of staff told us, "We work well together. We are quite a close team." We saw that most staff received annual appraisals with their managers, where they discussed their performance. The provider may wish to note that we found one member of staff had not received an appraisal for approximately two years. We discussed this issue with the registered manager who told us that the matter would be addressed straight away.

Staff were given the choice to take part in reflective practice sessions if they wished, where they could discuss any issues with a clinical psychologist. We saw that staff had regular staff meetings where practice issues were discussed. The registered manager told us that the provider was considering introducing additional clinical supervision for staff. Staff told us that they had been asked for their views on this matter by the provider. This meant that staff received appropriate professional development.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

During our inspection we saw information about complaints was displayed in a communal area and it was accessible to people. This meant that people were made aware of the provider's complaints system.

We spoke with people who used the service and they told us they had no complaints about the care and treatment they received.

The director of nursing explained that she was responsible for reviewing and investigating complaints and comments about nursing and specialist care, such as the provider's counselling service. Any medical complaints were reviewed by the medical director. We saw that the provider had an appropriate and up to date complaints policy. We looked at the forms that people were provided to record their comments. The form was called a 'Feedback form' and it was designed to record complaints and comments. This meant that people were able to make a complaint or comment in a format that met their needs.

We saw in the provider's complaints file that there had been 10 complaints or comments recorded in the last 12 months for nursing and specialist care. We found that the provider's forms had been fully completed. We saw that issues had been recorded and appropriate and timely actions had been taken by the provider to resolve matters. This meant that people's complaints were fully investigated and resolved, where possible, to their satisfaction.

We saw that a relative had completed a feedback form on the day of our visit. It stated that, "All the care is marvellous, but it would help relatives to have written instructions for mealtimes." We saw that the form had an action already recorded on it, 'Will take this to the team to look into possible solution.' This meant that people had their comments and complaints listened to and acted on, without the fear that they would be discriminated against for making a complaint.

We saw greetings cards in the nurse's office which contained compliments about the care and treatment people had received. One card stated, 'How very much the care and kindness given by you all was appreciated.' The director of nursing told us that if compliments were received about staff, she would let them know personally.

Records ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

The provider did not take proper steps to ensure that people were protected from the risks of unsafe or inappropriate care because accurate and appropriate records were not always maintained

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

During our previous inspection on 10 January 2013, we found that assessments of some patients' needs and risks had not always been completed and there were gaps in some people's records. During this inspection we looked at three people's records and found that there had been some improvements made to people's care records, however there were still areas of concern regarding gaps in people's records.

Since our last inspection we found that the provider had formed a documentation focus group and reviewed all documentation in people's care records. We saw that care record documents had been entirely replaced with new versions which were different and contained more information, such as new falls risk assessments. We spoke with staff that used the new documents. Staff told us that they were still, "Getting to grips" with the new system. One member of staff told us that the new system, "Flows better and feels safer."

Some staff told us that they had not received training on how to complete the new documents and they were aware that some of the records were, "A mess." We discussed this issue with the registered manager who told us that when they consulted staff members in the focus group about training, they were told it was not required. However the registered manager was aware there was a problem and was in the process of organising training workshops for all staff to enable them to learn how to complete the new care records appropriately.

We spoke with staff and asked them how care records were checked for quality. The registered manager told us that ward sisters asked senior staff nurses to check the quality of care records, but the checks were not documented and did not occur at an agreed regular time. Staff who used the care records told us that sisters and deputy sisters checked them and that it was "Ad hoc" and not recorded. We spoke with the compliance and audit manager about this issue and asked if care records had been formally audited. They told us that that records were currently monitored informally, however they would develop an audit tool in the future.

When we looked at people's care plans we found that a lot of them had not been reviewed. There were sections titled, 'Review' and 'Evaluation' on care plans, which had not been completed in many cases. We asked a staff member about one person's care records and they told us that this person's needs had changed significantly since they had been admitted. We saw that their care plans had not been reviewed. We raised this issue with the registered manager who told us that the review and evaluation section should be completed as soon as people's needs change.

We looked at the nursing assessment document in people's care records and found many gaps in people's care plans and assessments of risks associated with their care plans. For example on one person's records a care plan for an infectious disease had been started and not completed. It was not clear from looking at the care plan if the person had an infectious disease or not.

We found on one person's care records that their needs had been initially identified at the start of the nursing assessment, but there was not a care plan to reflect all their needs. This meant that their records were not fit for purpose.

We saw a plan for skin care on one person's care records. The plan had not been updated with the person's information. It was not fit for purpose because staff could not refer to it for instructions on how to care for this person's skin.

We found that pain assessments and daily pain indicator charts on people's records had either not been filled in and were left blank, or they had been part completed with gaps in the information. This meant that people's pain was not being monitored where required.

We looked at the advance care planning document on people's care records. We found on one person's records that it had not been completed at all. We discussed this matter with a doctor who told us that a doctor should complete this document as soon as possible after a patient's admission. They told us that the documents were not filled in as much as they should be because they were not appropriate. We were told that the advance care planning document was being reviewed at that time, to be inline with multidisciplinary changes in the local region. This meant that people's wishes for future care had not been recorded accurately.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Diagnostic and screening procedures Nursing care Personal care Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: The registered person did not take proper steps to ensure that people were protected from the risks of unsafe or inappropriate care. They did not ensure that accurate and appropriate records were maintained in relation to the care provided to each service user. Regulation 20 (1) (a)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 02 November 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

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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