Hospice in the Weald

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Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

Is the service safe?	Good ●

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 12 and 13 October 2015, at which a breach of legal requirements was found. Although we identified shortfalls in respect of medicines, people had not experienced any negative outcomes as a result and some remedial action was taken on the day of our inspection. However we found that some aspects of monitoring processes with regard to medicines needed to be consistently embedded to ensure that improvements were sustained over time.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook a focused inspection on 11 July 2016 to check that they had followed their plan and to confirm that they now met legal requirements.

This report only covers our findings in relation to medicines as part of the question 'Is the service safe?' You can read the report from our last comprehensive inspection on our website at www.cqc.org.uk.

Hospice in the Weald is a local charity covering a catchment area in West Kent and East Sussex that provide palliative and end of life care, advice and clinical support for adults with life limiting illness and their families and carers. They deliver physical, emotional and holistic care through teams of nurses, doctors, counsellors, chaplains and other professionals including therapists. The service cares for people in three types of settings: at the hospice in a 15 beds 'In-Patient Unit' plus up to two people in the day procedures room, or in their 'Hospice day service' that welcomes approximately 120 persons per week, and in people's own homes through their Hospice in the Home service that supports approximately 700 people. The service provides specialist advice and input, symptom control and liaison with healthcare professionals. This includes a training centre and offering advice and support to staff in nursing and residential care settings in the community, receiving up to 130 palliative care referrals per month. Services are free to people and the Hospice in the Weald is largely dependent on donations and fund-raising by volunteers in the community.

The services provided include counselling and bereavement support; an outpatient clinic; occupational and creative therapy, physiotherapy, chaplaincy and volunteer services that include approximately a thousand volunteers.

There was a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also the Nursing Director for the service. They oversaw the running of the service and were supported by a leadership team that included a chief executive officer (the provider) and five directors.

At our focused inspection on 11 July 2016, we found that the provider had followed their action plan. New monitoring processes with regard to medicines had been consistently embedded in practice since October 2015 and legal requirements were met.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Practices regarding the administration of medicines were in line with current controlled drug legislation to reduce risks for people.

Improved monitoring processes in regard to medicines were consistently embedded and sustained over time. People could be confident that staff followed robust monitoring processes in regard to all aspects of their medicines to ensure their safety.

Hospice in the Weald

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social care Act 2008 as part of our regulatory functions. This focused inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and provide a rating for the service under the Care Act 2014.

We undertook a focused inspection of the Hospice in The Weald on 11 July 2016. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 12 and 13 October 2015 had been made. We inspected the service's systems in respect of medicines, against one of the five questions we ask about services: 'is the service safe'. This is because the service was not meeting some of the legal requirements in relation to that question.

The inspection was carried out by one inspector.

Before our inspection we reviewed the information we held about the hospice and the provider's action plan, which set out the action they would take to meet legal requirements.

At the visit we looked at the service's policies and updates in regard to medicines, medicines administration records (MARs) and monitoring checks that were carried out in all aspects of medicines. We checked that each shortfall that had been identified at our previous inspection had been remedied and that improved monitoring systems were effective. We spoke with the chief executive, the registered manager, the matron for the Inpatient Unit and Therapies, and a consultant in palliative medicine.

Good

Is the service safe?

Our findings

Although we identified shortfalls in respect of medicines during our last inspection in October 2015, people had not experienced any negative outcomes as a result and some remedial action had been taken on the day of that inspection. Following our visit, the provider had sent an action plan to us that included an update of the service's medicines policy guidelines. This action plan and guidelines were clear, addressed each shortfall identified, and had established new revised monitoring processes in regard to medicines. At our focused inspection, we found these processes had been consistently applied and embedded in practice and improvements had been sustained over time.

No one was self-administering their medicines but systems were in place to ensure people's safety should they request to do so. Medicines administration records (MARs) were appropriately completed. There were no omissions in the administration records we looked at where a code or reason had not been recorded. Therefore checks could be carried out effectively to establish whether these medicines had been given, and establish the reason why they may not have been given at a particular time. This system ensured people were administered their medicines as prescribed and at the correct times to keep them safe.

Medicines were stored safely. The service's policy on the storage of medicines had been updated and clearly detailed the procedures to follow. The system to monitor minimum and maximum temperatures of medicines that needed to be kept within a refrigerator had been improved and followed up in practice. Temperatures were recorded and monitored daily to ensure people's medicines were safe to use.

Prescriptions forms were available to be used if required so that people could get medicines from community pharmacies. The service's policy on prescribing medicines had been updated and clearly detailed the procedures to follow. The system to track and monitor prescriptions had been improved and followed up in practice. The new system ensured that all of the prescriptions numbers were recorded and the doctor signed by each one when it had been used, stating the medicine and the name of the patient. This minimised the possibility of prescriptions forms being mislaid or misused.

The service's policy on sedation included clear updated guidelines about the reversal of sedation. A particular medicine that may be required in an emergency to reverse the effects of sedatives was available as per these guidelines. There were medicines available in a kit for use in a particular emergency. These medicines were in date and staff kept clear records of their weekly checks, as per the service's updated policy. This process ensured these medicines were monitored to ensure they were safe for people.

Medicines were stored safely and securely, in locked medicine cupboards within a secure treatment room or in secure lockers at people's bedsides. Medicines that require additional controls because of their potential for abuse (controlled drugs) were stored securely. The service complied with the regulations in the Misuse of Drugs Regulations 2001 with regards to the information supplied on a requisition and the supply of controlled drugs to patients during visits to hospital for appointments. There was a new system for transposing some of the information onto carbon copies of documentation.

When people went from the hospice to hospital for appointments, oral liquid medicines were supplied for people in coloured syringes dedicated for oral /enteral use. This was in line with the relevant patient safety alert from the National Patient Safety Agency (NPSA) 2007/19. The NPSA is a special health authority of the National Health Service (NHS) in England that monitors patient safety incidents, including medicines. This measure reduced any risk of people using the incorrect syringe and promoted their safety.

Controlled drugs were dispensed from individual prescriptions when people left the Inpatient Unit on a day or weekend leave, or when they visited a hospital for treatment. An updated policy on the 'dispensing of medications' had been written, the doctors had received training from a pharmacist and were aware of the procedures that were correctly applied in practice. This meant people could be confident their medicines were dispensed according to their individual needs out of the hospice.

There was an effective system in place for obtaining medicines including those required in an emergency. Prescribing was done on dedicated treatment charts and records of administration were clearly documented on the charts. There was a separate chart for the administration of medicines via a syringe driver (portable pumps that are used to provide a continuous dose of medicine through a syringe). The prescription appropriately indicated the syringe driver was to be administered over 24 hours. There was a system in place with the use of stickers to identify if people had more than one chart. There was a clear way of identifying whether a medicine needed a reduced dose because of renal impairment and there was also a mechanism to allow nurses to give a range of discretionary medicines which had been pre-approved by the doctor. This allowed nurses to respond in a timely way to treat people's minor ailments.

There was comprehensive information available to people about medicines being used outside the terms of their UK licence, or medicines that may not be licensed in the UK. The use of such medicines is widespread in pain medicine and palliative care because the mixing of two or more licensed medicines is considered to produce an unlicensed preparation. A patient information leaflet was available and if necessary a discussion with the doctor allowed people to make an informed choice about their treatment.

Up to date references were observed to be in use which provided information about the safe and correct use of medicines and comprehensive policies and guidelines were in place. Regular medicines management meetings were taking place and medication incidents were reported and reviewed. Actions had taken place following previous dosing errors with syringe drivers to ensure that recurrence of such errors could be minimised. There were regular and effective competency checks for staff administering medicines. When these recorded checks had identified a need for a refresher course this was provided. To complement medicines audits, two trustees with clinical experience and relevant qualifications had undertaken an unannounced inspection to check on the progress of the action plan developed following our last visit. The external pharmacist also carried out weekly spot checks. As improvements had been implemented and new processes embedded in practice, people could be confident that all aspects of their medicines were monitored effectively to keep them safe.