

St Raphael's Hospice

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

Overall summary

St Raphael's Hospice is operated by The Congregation of the Daughters of the Cross of Liege. It is a voluntary organisation, part of the registered charity of the English Province of the Daughters of the Cross of Liege. The hospice will become a charity in its own right in Spring 2020.

The hospice provides end of life and palliative care to people living in the South London Boroughs of Sutton and Merton. The hospice accepts referrals made by GPs,

specialist nurses or hospital consultants. A team of specialist consultants, doctors, nurses, health care assistants and a range of other health and social care professionals, therapists and volunteers provide care, treatment and support to people with a life-limiting illness and their families/carers and friends.

The hospice comprises of a 14 bedded in-patient ward, the Jubilee day care centre, overnight family accommodation and a café known as the Orangery that is

Summary of findings

open to the public. There are various community teams that operate out of the hospice which include the Clinical Nurse Specialist Community Palliative Care Team (CPCT), 'Hospice at Home' and 'Hospice neighbours' services that provide people and their families care and support at home. The hospice also has a pastoral and counselling service for both people and their families. At the time of our inspection, there were eight people staying on the ward at St Raphael's and approximately 250 people receiving community palliative services at home.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced visit to the hospice on 11th and 12th November 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so, we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

Our rating of this service stayed the same. We rated it as **Good** overall.

- Staff kept patients safe from avoidable harm and abuse. Risks were assessed, monitored and managed appropriately.
- Patients care and treatment records were clearly detailed and accurate in content. They were stored securely and managed safely.
- Staff recognised incidents and knew how to report them. Managers investigated incidents and made improvements to the service.
- Staff followed best practice in relation to infection prevention and control.
- Staff had the appropriate skills, training, knowledge and experience to deliver effective care and treatment. Care and treatment was delivered in line with evidence-based practice.
- Staff involved patients and carers in decisions about their care and treatment.

- Staff cared for patients with compassion, treating them with dignity and respect. Staff truly respected and valued patients as individuals and empowered them as partners in their care, practically and emotionally, by offering an exceptional service.
- Services provided aimed to meet the needs of people from their whole community, and the needs of the population served, which ensured flexibility, choice and continuity of care.
- There were clear processes for staff to manage complaints and concerns.
- There was an open and transparent culture, with engaged and experienced leadership.

However, we also found the following issues that the service provider needs to improve:

- The hospice should improve the electronic notes system so that it is more user friendly and easier for staff to navigate.
- The hospice should replace the worn carpet within the inpatient areas to reduce the risk of slips, trips and falls.

We found the following areas of outstanding practice:

- Staff within the service demonstrated compassion and dedication to finding innovative ways to support patients with their end of life care. Staff and patients could provide many examples of how the service had ensured patients received care individualised to their holistic needs.
- People's individual needs and preferences were central to the delivery of tailored services. The staff were exceptionally caring, compassionate and empathetic towards both the patient and their relatives.
- Staff completed comprehensive and holistic end of life care plans. The care planning within the service focussed on all elements of the patients care including their spiritual and emotional needs.
- The service has hospice biographers, who alongside the patients would write patient biographies that they can leave as a memoir of their life for their family and friends.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Summary of findings

Dr Nigel Acheson

Deputy Chief Inspector of Hospitals (London & South)

Summary of findings

Our judgements about each of the main services

Service

Hospice services for adults

Rating

Good



Summary of each main service

Hospices for adults was the only activity provided at this location.

We rated this service as good because it was safe, effective, caring, responsive and well-led.

Summary of findings

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Good 

St Raphael's Hospice

Services we looked at

Hospice services for adults;

Summary of this inspection

Background to St Raphael's Hospice

St Raphael's Hospice is operated by The Congregation of the Daughters of the Cross of Liege. It is a voluntary organisation, part of the registered charity of the English Province of the Daughters of the Cross of Liege. The Hospice will become a charity in its own right in Spring 2020.

The service has a registered manager who was also the hospice's Director of Care Services. A registered manager is a person who has registered with the Care Quality

Commission (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 hospice was inspected last in November 2016 and was rated as good over all. We inspected the service on 11 and 12 November 2019, our inspection was unannounced.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and another CQC inspector. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

Information about St Raphael's Hospice

The hospice is made up of one inpatient unit with 14 beds and community services; and is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury.

During our inspection, we visited the inpatient unit, the day therapy services and attended two home visits with a member of the specialist palliative care community nursing team. We spoke with 20 staff including registered nurses, health care assistants, reception staff, administration staff, medical staff, chaplaincy, housekeeping, laundry staff, porters, maintenance and senior managers. We spoke with eight patients and eight relatives. During our inspection, we reviewed eight sets of patient records. We reviewed information sent to us by the service prior to the inspection and data requested during the inspection,

Activity (September 2018 to August 2019)

- In the reporting period September 2018 to August 2019, the service saw 3,105 patients.

The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- Zero Never events
- Two serious incidents
- Zero incidences of hospice acquired methicillin-resistant *Staphylococcus aureus* (MRSA), methicillin-sensitive *Staphylococcus aureus* (MSSA), hospice acquired E-Coli and hospice acquired *Clostridium difficile* (c.diff).
- 12 complaints received
- 65 compliments received

Services provided at the hospice under service level agreement:

- Pharmacy

There were no special reviews or investigations of the hospice ongoing by the CQC at any time during the 12 months before this inspection. The hospice has been inspected twice since registration with CQC.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Our rating of safe stayed the same. We rated it as **Good** because:

Good



- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

However, we also found the following issues that the service provider needs to improve:

- We found electronic records were difficult to navigate, which meant that staff could not always access patient records in a timely and efficient way.

Summary of this inspection

- We found that the carpet in the inpatient area was worn and was a slips, trip and falls hazard and required replacement.

Are services effective?

Our rating of effective stayed the same. We rated it as **Good** because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

Good



Are services caring?

Our rating of caring stayed the same. We rated it as **Good** because:

Good



Summary of this inspection

- Staff went above and beyond their duties, treating all patients with the compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs and went above and beyond to meet these. For example, we were told of instances where the hospice converted the family room to a cinema, so that a palliative patient with small children could have a family movie night before they passed away. Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. All patients and relatives told us they received outstanding care and treatment, staff were 'angels' and they would not have been able to cope without them.

Are services responsive?

Our rating of responsive stayed the same. We rated it as **Good** because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Good



Are services well-led?

Our rating of well-led stayed the same. We rated it as **Good** because:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Good



Summary of this inspection

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required. Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.






Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospice services for adults	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Hospice services for adults

Safe	Good 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

Are hospice services for adults safe?

Good 

Our rating of safe stayed the same. We rated it as **good**.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training for all staff included equality and diversity, health and safety at work, control of substances hazardous to health (COSHH), fire safety awareness, infection control, information governance, manual handling, basic life support and safeguarding adults and children at level two and level three and conflict management.

Each individual mandatory training topic had a compliance target of over 80%, which was met in all subjects. We spoke to nurses regarding their confidence in undertaking cardiopulmonary resuscitation (CPR) should an emergency situation arise and all the nurses we spoke with were confident in their ability to perform CPR. We also observed nurses moving patients and found that all patients were moved safely and with dignity. Since our last inspection the hospice had added advanced communication to their mandatory training. We saw that all staff had attended this training.

There was a structured induction programme for staff to ensure they had the skills needed for their roles. The service's induction programme included ensuring new staff could access the computer systems, meeting with staff in different teams, and dedicated time to complete

mandatory training. Since our last inspection, the hospice had introduced a clinical facilitator to facilitate consistent induction and management of rotation of staff through all departments, as well as a practice development nurse.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

The clinical services lead was the service safeguarding lead and had been trained in adult safeguarding level 3. Although the hospice was for adults only, there were arrangements in place for children's safeguarding, in line with national guidance. The hospice social worker was the safeguarding lead for children and had been trained in level 3 safeguarding children. The clinical nurse specialist was the safeguarding link nurse for both the community and inpatient areas. We were told that both the social worker and the clinical nurse specialist were enrolled on safeguarding adult level 3 courses and were due to complete these by March 2020.

Staff we spoke with confirmed that they had received safeguarding training at a level relevant to their role and knew how to recognise abuse and neglect. We saw that 90% of staff had received safeguarding training at a level relevant to their role.

The service had a formal system in place where alerts for known safeguarding concerns could be activated, and staff were aware of the correct pathways to follow to raise their concerns.

Safety was promoted through the recruitment and induction of volunteers and staff. The service used an

Hospice services for adults

external company to determine which volunteer roles required a Disclosure and Barring Service (DBS) certificate. DBS checks involve a government department carrying out a criminal record check that results in a certificate being issued to an individual.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The clinical environment we visited during our inspection was visibly clean and tidy. All areas had evidence of a cleaning schedule, which was signed when staff had completed the cleaning duties.

We checked monthly, weekly and daily cleaning schedules and associated audits, which showed that all areas of the service were cleaned as required. We observed the environment was kept free of obstacles and hazards which enabled people to move freely around the ward. We saw chemicals and substances hazardous to health (COSHH) were stored safely in locked cupboards when they were not in use.

The service had an infection prevention and control (IPC) lead, and staff held regular IPC and health and safety meetings. The meetings discussed IPC incidents and infection rates. The hospice had reported no incidents of healthcare acquired infections, such as methicillin resistant *Staphylococcus aureus* (MRSA) or *Clostridium difficile* (C diff) in the 12 months prior to our inspection.

The service undertook hand hygiene audits for the inpatient unit, day therapy centre and in the community. We reviewed the last completed audit and it demonstrated compliance with the service's hand hygiene policy. The clinical areas had dedicated hand washing facilities. Staff had access to hand sanitizer and disposable wipes for the cleaning of surfaces, clinical rooms and inpatient bedrooms.

Staff followed the service's bare below the elbows policy as well as using appropriate protective equipment (PPE) such as gloves and aprons to deliver personal care. We observed staff washing their hands before and after patient contact.

There were effective arrangements in place to prevent the spread of infection when caring for patients who had died. Systems ensured deceased patients left the hospice in a timely and dignified way and any risks of cross-infection were appropriately managed.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The hospice consisted of two single storey buildings; the main building which housed the inpatient unit, restaurant and day centre; and the conference centre which was being refurbished to become the day centre. We saw that both buildings were easily accessible for everyone. We saw that accessible toilets were available for patients, staff and families.

The ward area and patient rooms were uncluttered, visibly clean and tidy. The ward area had single rooms, each with its own balcony that led to communal gardens. Each balcony had screens to maintain privacy and dignity. We saw the rooms were decorated to a high standard with lots of space for family members and friends to visit the patient, as well as stay overnight if they desired. Fold away beds were provided for people staying overnight with the patient. We saw that there was also a family room where relatives could stay overnight. This room included provisions for children as well as adults. However, we saw that in the main corridors, the carpets had become very worn in places. This could lead to trip hazards. The hospice told us there were plans to replace the carpets but were unable to tell us when the carpet would be replaced.

We reviewed the records relating to maintenance and servicing of all equipment used by the service and saw the equipment servicing was up to date.

Syringe drivers were provided by the service, serviced annually and maintained by an external company. We saw that staff had been trained to use syringe drivers and their competency to do so assessed.

Staff in both the inpatient and community areas told us specialist equipment such as syringe drivers and hoists were readily available.

Hospice services for adults

Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme. During our inspection, the equipment we reviewed were serviced within the last 12 months. We reviewed documents that showed the equipment had been serviced annually in line with the manufacturer's guidance. All electrical equipment had been tested for safety and the premises had an electrical safety check.

The service had a maintenance team who were onsite during working hours and provided an on-call service out-of-hours. Staff told us the maintenance team were responsive to calls and fixed equipment promptly.

Staff in both the inpatient area and the community told us they had access to specialist medical equipment such as profiling beds, pressure relieving mattresses and pressure relieving boots.

The service had appropriate arrangements in place for the management of clinical waste and sharps. For example we saw that waste was correctly segregated and sharps bins were correctly labelled and stored. Arrangements for storing, classifying and labelling clinical waste kept patients and staff safe.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. Staff identified and quickly acted upon patients at risk of deterioration.

We saw staff carried out risk assessments for all patients. Inpatient records included for example; an integrated nursing and medical assessment, mental capacity assessment, do not attempt cardiopulmonary resuscitation form if appropriate, a risk assessment for pressure ulcers, and a malnutrition universal screening tool (MUST). Patients were also assessed for their risk of falls, had a full cognitive assessment, and if bedrails were used, this was clearly documented and in accordance with their care plan. There were review dates for all assessments, which were all dated and signed.

The service positively managed risks that people might experience at the end of their life, including risk of pressure ulcers and falls. The service completed two-hourly comfort rounding and regularly reviewed each patient. Staff used nationally recognised tools to assess

each person's risk of developing pressure ulcers. These were re-assessed weekly. Each patient's skin integrity was checked and recorded daily and formed part of the services two-hourly comfort rounding. We saw the patients had the correct pressure relieving equipment in place according to their level of risk.

Care plans were individualised to cover the psychological as well as physical needs of patients. Where a patient had changing needs, for example, becoming increasingly uncomfortable, staff adapted their care plan accordingly. There was a daily multidisciplinary team meeting which provided an opportunity for further review and amendment of care plans for both inpatients and patients who were in the community.

Staff could access medical reviews for patients 24 hours a day. Both the inpatient service and the community service were staffed by nurse specialists who could call on doctors and consultants to provide specialist input as needed.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Nursing staff told us that they felt staffing levels were appropriate and they had time to give compassionate care. Patient care was also supported by a wider team including healthcare assistants, therapists and domestic staff. The service had determined a minimum safe staffing level using a nationally recognised staffing tool.

The service ensured a senior nurse was always on duty on the inpatient unit and that staff had access to an on-call manager in and out-of-hours to escalate any staffing concerns that arose. The service generally did not use agency staff unless in very unusual circumstances. The service used bank staff, largely their own staff, who provided cover as needed. We saw that all bank staff received an induction to the service. During the days of our inspection we saw the planned levels of staffing matched the actual staffing levels and there was a strong skill mix among the nursing team.

Hospice services for adults

We saw the nursing staff in the community teams were flexible and covered hours from 8am to 8pm. There was a minimum of two clinical nurse specialists (CNS) on duty to cover telephone triage and visits, as well as four nurse prescribers working at an advanced level. We saw that there was a team of healthcare assistants who supported the community team as Hospice @ Home.

The service had 4.0 whole time equivalent (WTE) registered nursing vacancies and no healthcare assistant vacancies across the inpatient unit and the community service. The service was actively recruiting for these posts during our inspection. The service had a sickness rate of 5% between June 2019 and August 2019 in relation to nursing/ allied health staff, and 10% in relation to healthcare assistants.

Medical staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had access to appropriate medical input. There was one full time consultant and one doctor above foundation year one (FY1) on duty daily. The service also had a GP trainee doctor who rotated on a three monthly basis. Out-of-hours, the first on-call doctor was a registrar or specialist doctor. The second on-call was always a consultant. Staff told us that the out of hours doctors were easily accessible, and were available within 30 minutes. Staff had access to a specialist palliative care consultant 24 hours a day.

We saw from rotas that the planned medical staffing skill mix matched the actual and could be flexed to meet patient need. Medical staff attended the multidisciplinary catch up meeting every day.

The service had 1.2 whole time equivalent (WTE) registered medical staff vacancies. The sickness rate for medical staff between June 2019 and August 2019 was 9%.

Medical staff we spoke with told us they had received an effective induction when starting at the service.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

People's individual care records were written and managed in a way that kept them safe. Staff kept detailed records of patients' care and treatment, which enabled staff across the varying shifts to understand what was required of them. We saw that records were kept both electronically and on paper.

The information needed to deliver safe care and treatment was available to staff in a timely and accessible way. Electronic notes were stored on a live system that was used throughout the service, meaning that staff could access the most current notes and update them no matter where they were. For example, nurses in the community could access the medical notes for a patient immediately once they had been written, even if the doctor was on the inpatient unit at the time. However, we noted that the electronic notes were not always easy to navigate and required staff to click through several pages/sections to find what they were looking for. For example, we asked staff to show us some of the patient risk assessments. Staff had difficulty locating them and had to click through several sections in order to find them, which they found to be time consuming.

Patients paper records, including prescription charts, were stored securely in the nurse's station. The area where the notes were kept was locked and could only be accessed by authorised staff.

We reviewed eight patient care records. The records contained detailed person-centred care plans, which clearly identified patients' emotional, social and spiritual needs alongside their physical health needs. Staff completed care plans appropriately and we saw they recorded when care was carried out in line with the care plan. Staff reviewed care plans regularly or when a patient's circumstances changed.

Staff could access patient specific information from the care plan which included information on communication, psychological and mental health and end of life care. All care records contained a 'getting to know me' document

Hospice services for adults

that detailed the patient's needs and preferences, including conditions such as dementia and challenging behaviour. This was completed in all of the care records we reviewed.

Information needed for each patient's ongoing care was shared appropriately in a timely way. The service sought and obtained patient consent to share information with other services such as GPs. The service sent discharge letters to patients GPs.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

During the inspection, we reviewed eight prescription charts. We saw patients' prescriptions and administration records were accurate, complete, legible and stored securely. The allergy status of patients were recorded on prescription charts. We saw that all medicines had been administered as prescribed, and any omissions had reasons recorded. We spoke with four members of staff in relation to the management of medicines and all were able to tell us about the service's policy and procedures.

Medicines were prescribed, prepared and administered by competent staff. Staff told us they had annual medication competency assessments completed, and we saw that the service had four non-medical nurse prescribers in post. This meant that patients, including those who were at the end of their life, did not have to wait for a doctor to prescribe medicines.

The service had a controlled drugs accountable officer. Controlled drugs (CDs), which are medicines that require additional controls because of their potential for abuse, were managed effectively. The controlled drugs were stored appropriately and in accordance with legislation. We were told that CDs that were out of date or surplus to requirements were destroyed on the premises by appropriately trained registered nurses. We saw that clear records of this were kept. Pharmacists carried out regular audits on controlled drugs.

The service had a service level agreement with an independent pharmacy. A clinical pharmacist attended the hospice weekly to undertake a review of prescription

charts focusing on medication use, safe and effective prescribing accuracy, review of stock control including monitoring of expiry dates, audit of CDs and monitoring of the daily fridge temperature.

We saw the service used an online reporting service that allowed communication with the wider clinical team regarding medicines. This allowed the pharmacist to highlight any areas of concern or good practice. The pharmacist also delivered education sessions, attended the quarterly drugs and therapeutics committee meeting to inform and update on new guidelines/alerts.

Medicines were stored safely and securely, in locked medicine cupboards within storage rooms. There was a system in place to check that all medicines were within date and suitable for use. We saw that medicines were available for use in an emergency and these were checked regularly. Medicines requiring cold storage were kept in a locked refrigerator within recommended temperature ranges and this was monitored regularly. All inpatient rooms had a lockable medicine cupboard and if patients self-medicated, they would have access to the keys.

During the inspection, we spoke with five patients regarding their medicines. All five and their families felt they were given clear and accurate information on medicines, including their expected effect and any possible side effects. Medicine related incidents were recorded and monitored, lessons were learnt, and action plans were in place to ensure recurrence of errors were minimised.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff were aware of their incident reporting roles and responsibilities. There was an incident reporting policy which explained the process. Learning from incidents was discussed during team meetings. Lessons learnt, and

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actions plans developed as a result of investigations were clearly documented. For example, we saw that the hospice commissioned an external company to deliver education on communication in response to an incident. Staff reported all clinical incidents and near misses on the incident reporting system and these were checked monthly by the clinical risk management group.

Staff we spoke to were aware of the principles of duty of candour and being open and honest. The Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Service managers told us Duty of candour was covered as part of mandatory training and the staff we spoke with confirmed this.

The service reported no never events from July 2018 to June 2019. A 'never event' is a serious patient safety incident that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event reported type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

The service reported two serious incidents from July 2018 to June 2019, of which one was a near miss, meaning harm did not actually occur. Staff we spoke with were aware of both incidents, the lessons learnt, and measures that had been put in place as a result.

Are hospice services for adults effective? (for example, treatment is effective)

Good 

Our rating of effective stayed the same. We rated it as **good**.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients in their care.

The service used a combination of national guidelines to assess and treat the needs of end of life and terminally ill patients. This included guidance produced by the National Institute for Health and Care Excellence (NICE), and the Hospice UK. Examples of those we looked at included guidelines on the management of pain, breathlessness and symptom control.

We saw anticipatory medicines for pain, breathlessness, pain management, nausea and vomiting, distress, agitation and seizures were prescribed and given in line with NICE guidelines for care of the dying adult in the last days of life and palliative care for adults.

Staff implemented care planning for patients as early as possible. Care plans were identical in both the inpatient and community settings, and when patients transferred between the two areas of the service patients confirmed that their care was delivered in line with their wishes. Care planning included discussion about support for the patient's family and we saw evidence of families and friends being emotionally, and practically helped to support the person using the service.

The hospice had increased its early identification of preferred place of death for their patients and were actively reducing admissions when a patient indicated they would prefer to stay at home.

Patient's attending the hospice in both the day therapy service and inpatient unit had the opportunity to develop an advance care plan. Patients had a clear personalised care plan that reflected their needs and this was up to date. Staff delivered care to patients in the last days of life that met the 'five priorities of care of the dying person'. Individual care plans took account of symptom control, psychological, social and spiritual support and we saw evidence of discussion with patients and relatives recorded in care plans. This gave us assurance that care plans were agreed and developed with the consent of the patient.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

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Patients received a nutrition and hydration assessment on admission. Staff used a nutrition screening tool to assess the food and hydration needs of patients. Staff fully and accurately completed patients' fluid and nutrition charts where needed. We saw evidence of this when reviewing patient's records.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. All the records we reviewed showed staff had completed the malnutrition universal screening tool risk assessment tool.

Patient's nutrition and hydration was assessed and monitored as part of patients personalised care plan for the last days of life; this included a mouthcare and oral hygiene plan. Discussions with patient's relatives about nutrition at the end of life were clearly documented in the plan. Patients were offered a choice of meals from a menu each day and provided snacks and drinks throughout the day when required.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Staff made sure patients had support with nutrition and hydration to meet their needs.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We observed staff checking patients for any symptoms of pain and offering analgesia in line with the service's medication policy. Patients received pain relief soon after it was identified they needed it, or they requested it.

Staff prescribed, administered and recorded all pain relief accurately. We saw that pain was regularly assessed and pain relief given where appropriate in all of the patient records we looked at. Patient's we spoke with told us that their pain had been well managed by staff.

The hospice managed the pain of people who were approaching the end of their life effectively. Staff

assessed and monitored patient's pain during comfort rounds as part of patients care. Staff could access different pain assessment tools including those suitable for people who were not able to verbalise their pain.

Anticipatory medicines were prescribed appropriately in people identified as approaching the end of life Staff recorded when as required medicines were given for pain relief. At a morning MDT meeting, we saw that all patients' pain and symptom control were discussed as standard and plans were made to adjust these as needed.

We observed a member of the community nursing team assessing a new patient. As part of a comprehensive review, they discussed a pain management and symptom control plan with the patient and their family. Patients in the community told us that if they needed additional pain relief during the night they were able to call the hospice who would give them advice and arrange for more pain relief if required. Doctors were able to use the live electronic system to issue immediate prescriptions so that patients symptoms were well controlled.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service monitored the quality of the services and the outcomes for patients receiving care and treatment through their annual audit plan.

The service used the Integrated Palliative Care Outcome Score (IPOS). This is a collection of tools that measure a patient's physical symptoms, psychological, emotional and spiritual, and information and support needs. Each patient was given an IPOS score when they were discussed at the multidisciplinary team meeting.

All the patients records we reviewed had an individualised care plan that set out their advanced care preferences. It covered activities of daily living, family and carer support, infection control, mental capacity, tissue viability, advance care planning and symptom management. There was provision for recording preferred place of care and death within the electronic record. The records were regularly reviewed and audited.

The service participated in all relevant national clinical audits for hospice care. Managers carried out a yearly

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audit programme which was created using tools from the Hospice UK. We saw that this included participation in national, regional and local audits. Staff participated in relevant quality improvement initiatives, such as local and national clinical audits. Audit outcomes were shared with local teams and the wider multidisciplinary team.

We were told that the service used information from the audits to improve care and treatment. The outcomes of audits were monitored and shared with staff through the multidisciplinary meetings.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Patients had their needs assessed by staff with the right skills and knowledge. The service ensured that staff competencies were assessed regularly by the practice educator. Staff were assigned mentors responsible for signing off their competencies. Staff mentors oversaw mentoring, clinical and group supervision. Managers supported nursing staff to develop through regular reflection and clinical supervision of their work.

The service offered staff continuous learning opportunities to enhance their current roles. Courses provided included breaking bad news, communication skills and a range of other end of life and palliative care courses provided by an external organisational. Staff told us the training was extremely well received and had been useful for their role at the service.

Staff were encouraged and given opportunities to develop. Managers made sure staff received any specialist training for their role. This included providing specialist in-house training courses on breaking bad news, symptom control and breathlessness in end of life care.

All newly qualified members of staff were provided with monthly one to one sessions and yearly appraisal. Staff told us that they completed annual appraisals with their line managers and that they found these meaningful. The appraisal compliance rate for all staff was 98%, which met the service target of 85%.

The service had an established induction process in place for all grades of staff. The induction process included

competencies to be signed off once completed. Staff also shadowed another member of staff as part of their induction program. Bank staff received the same induction that permanent staff received.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

There were daily multidisciplinary team meetings. These were attended by nursing staff, doctors, health care assistants, and therapy staff. The service held morning meetings which were attended by the doctors, nurses and the allied health professionals. Staff told us this meeting helped target patients who may require greater input across the multidisciplinary team in advance of their visit/ward round to ensure those patients needs were met quicker.

Doctors at the local NHS hospital worked alongside colleagues at the hospice, to enable co-ordinated care for patients. A palliative consultant from the local NHS hospital visited the hospice several times a week to support onsite doctors.

We observed multidisciplinary team meetings and saw positive working relationships between all staff. We saw that the care and treatment of every patient was discussed at the meeting and a management plan put in place.

Nursing staff, including bank nurses, told us that doctors were approachable and part of the team. Doctors told us they supported the nurses to do their job and felt proud to be a part of the team. Healthcare assistants told us they felt able to contribute actively to the team.

Staff worked in partnership with external providers of end of life care in assessing, planning and delivering care and treatment. This included GPs, primary care nursing teams, allied health professionals, social care providers, secondary care and other voluntary sector workers. We saw the hospice had clear processes in place with local providers in the event that a patient required transfer to hospital.

There was a holistic approach to delivering care and treatment to all people who used the service. This included assessing their nutrition, hydration and pain

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relief needs. The service's allied health professionals attended and contributed into meetings to discuss their input for patients' needs. We noted that the consultant actively sought the input of allied health professionals and registered nurses and that they worked together as a team to come up with a plan of care for patients.

Seven-day services

Key services were available seven days a week to support timely patient care.

The service ran seven days a week, 365 days a year. People could access most of the services seven days a week.

Staff could call for support from doctors and other disciplines, including allied health professionals 24 hours a day, seven days a week. Consultants led daily ward rounds, including weekends.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

There were health promotion materials displayed throughout the hospice to support ongoing health promotion. Leaflets were available in the hospice on topics such as living positively with cancer, managing breathlessness, symptom management and Macmillan services.

Staff identified people who could benefit from extra support and discussed changes to care and treatment with those patients and those close to them. Staff supported people to maintain their own health and wellbeing.

The hospice offered complimentary therapies as part of the day care and drop in services. These services included massage, aromatherapy and relaxation techniques. There were dedicated rooms allocated for complimentary therapies.

Consent and Mental Capacity

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions.

All nursing staff completed training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act 1983/2007, Mental Capacity Act 2005 and they knew who to contact for advice.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff were able to describe the MCA and actions to take when assessing service users. Staff within the hospice confirmed they sought consent from patients before providing care and treatment. We saw written consent within the patient's files were completed fully and were legible.

The service looked at each patient's mental capacity as part of the personalised care for the last days of life plan. We saw evidence that capacity was assessed prior to decisions about end of life care being made. Where a patient had been assessed as not having the capacity to consent to treatment, staff acted in their best interests and this was discussed and agreed at the multidisciplinary team meeting.

Are hospice services for adults caring?

Good 

Our rating of caring stayed the same. We rated it as **good**.

Compassionate care

Staff truly treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

All patients we spoke with confirmed that staff treated them well and with kindness, with all telling us the staff were exceptionally kind, caring and understanding. The relationships between patients, relatives and staff were highly valued by staff and were encouraged and supported by the leadership. Two patients and their families specifically told us they could not have possibly coped without the compassion and support given to them by the staff, both in the hospice and by the community team.

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We observed staff being continually kind and compassionate as they put patients and their relatives at ease. We observed that patients, family members and friends were always treated with dignity and respect. We also observed nurses moving patients and found that all patients were moved safely and with dignity. We saw that patients were offered information on how to access emotional, psychological and bereavement support and that this was compassionately given to them both verbally by staff, as well as in information leaflets. The service encouraged patients to provide feedback from their experience after each visit. We were provided with results from this feedback which was all highly positive.

Patient's individual preferences and needs were always reflected in how care was delivered. We saw that the inpatient unit used a 'What's Important to Me' whiteboard in each room. These were filled in on admission to the unit, to allow all staff to gain a more in depth understanding of each patient and their individual needs, and what was really important to them as individuals. We saw these boards included what the patient liked to eat, how they wished their hair to be styled, their pets, their previous occupations, information about their families, books they liked to read and religious wishes. Staff told us this these boards also allowed patients to communicate to their families things that are important to them that they may have previously had difficulty talking about, such as their funeral wishes. We saw that the boards were updated as the things that were important to the patient changed.

The service held birthday parties and other special occasions so that patients could celebrate these special occasions with their loved ones. We were told of a patient who was imminently reaching the end of their life who wished to take their young children to the cinema. The service arranged for the family room to be converted to a 'cinema' to allow the patient and their family to watch a movie together. The same patient wished to have a 'date night' with their spouse. The service arranged for the family room to be converted into a 'restaurant', with the patient and their spouse ordering a takeaway meal and having time together away from their inpatient room.

Nursing staff were passionate about creating positive memories for patients and their families when staying at

the inpatient unit. Staff enabled families to be together. For example, if the patient was well enough, they would eat at a table in the communal area away from the patient room.

The hospice was designed so that patients had their own personal balcony. These had partitions in place to separate each person's balcony so that patients and their families were able to enjoy the outside environment in privacy. Staff accommodated patient's wishes to go outside each day, by assisting them to move on to their private balcony. We saw that one patient wanted to go outside each day with their family. The staff ensured the patient was moved onto their private balcony each day so that they could be outside with their family, observe the wildlife, and see their grandchildren playing on the grassy area.

Staff consideration of people's privacy and dignity was consistently embedded in everything they did. Staff ensured they protected patient's dignity when providing personal care by closing doors and curtains to bedrooms.

The dignity of deceased patients was maintained through the services processes for performing last offices and transferring the deceased person to the services cold room to await collection by a funeral home. Last offices is the process to prepare the deceased for a funeral home.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

We saw staff were positive and attentive to the needs of patients at the hospice. We observed staff providing kind, thoughtful, supportive and empathetic care. Relatives also commented on how supportive the staff were. They provided them with assurance and reassurance which enabled patients to relax and settle well into the hospice and accept the care and support provided.

Relatives could attend one on one bereavement sessions with a psychologist or bereavement support groups. One relative that we spoke with told us the nursing staff provided emotional support to them daily. We saw that

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leaflets about the services were readily available for both patients and relatives. Relatives told us that staff had showed them the leaflets and allowed the relatives to look at them in their own time if they wished to.

Staff supported patients well and we saw they were communicating sensitively and thoroughly with patients and those close to them. Patients and relatives told us they felt they could ask staff any questions and they were given support when they were upset.

Staff recognised and respected the totality of people's needs. They always took people's personal, cultural, social and religious needs into account, and found innovative ways to meet them. The aim of the service was to relieve as many worries for a patient as possible, so they could concentrate on caring for the whole person and their relatives. Patient's emotional and social needs were seen as being as important as their physical needs. We saw that one of the sisters of The Congregation of the Daughters of the Cross of Liege came to the inpatient area daily, offering emotional and spiritual support to any patient and their families who wished to receive support. We saw that patients with different religious beliefs were also able to receive the spiritual care they wished for, and other religious leaders were invited to visit the hospice. This included honouring spiritual and cultural wishes of the deceased person and their families, at the time death, an also while preparing the body for transfer to the cold room.

Staff recognised the need for patients and those close to have access to, and links with, their advocacy and support networks in the community and the service provided support to them to do this. The service had hospice biographers, who in collaboration with the patient would record patient biographies that provide a spoken memoir of their life for their family and friends.

The complementary therapy team offered a range of therapies to support patients and their relatives including massage and aromatherapy. The spiritual care team ran events to support and remember loved ones such as the annual 'Light Up A Life' service, a bereavement service held twice a year for families bereaved over a year. The hospice recognised that support for relatives was often long term and made contact with relatives 6 months after their bereavement.

We saw that there was a group of relatives who had suffered bereavements who now volunteered at the hospice, and also had coffee mornings/ catch ups in the restaurant.

The day therapy service included the option of a 'men's den'. This allowed men to get together while undertaking activities which allowed for them to have a support network. This was open to both patients, relatives and those that have been bereaved.

During our inspection, we saw that the day unit was being moved to the conference centre. Managers told us this was to allow for more space for an ever expanding service, as well as allowing patients to attend the day centre without having to enter the hospice, as some newly diagnosed patients may not wish to attend activities in the same building as the inpatient unit.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff always communicated with patients about their care and treatment in a way they could understand. Patients and relatives we spoke with told us that staff always involved them in decisions about their care and treatment. During the inspection we observed the service waiting for family members to visit before discussing treatment options, so that both the patients and their relatives were involved in decision making around their care.

The service had a visible patient-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity and independence where possible. Patients and those close to them were actively involved in their care.

Staff made sure that people who used services and those close to them were able to find further information, including community and advocacy services. Patients and relatives told us they could easily ask questions about their care and treatment. Staff were fully committed to working in partnership with people. Staff

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routinely involved people who used services and those close to them (including carers and dependants) in planning and making shared decisions about their care and treatment.

People's carers, advocates and representatives including family members and friends, were identified, welcomed, and treated as important partners in the delivery of their care. Patients told us they valued the relationships they built with the staff and they felt staff often went 'the extra mile' for them when providing care and support, and that this was relevant for both the community and the inpatient staff.

We saw evidence in patient care records that staff involved patients and those close to them in the decisions about the patients' care and treatment and in developing their care plans. Patients and their relatives told us that staff answered questions about care and treatment openly and the information provided to them was clear. We observed the community nursing staff involving and engaging patients and their relatives in discussions about care planning.

Staff supported patients to make advanced decisions about their care. Patients were provided with support and information about their options for care, and conversations were had with patients about their preferred place of care. We saw staff talking to patients and their families about death and the dying process. They were very compassionate and caring towards patients or family members who became upset. They enabled the family of patients to ask as many questions as they wanted to.

Are hospice services for adults responsive to people's needs?
(for example, to feedback?)

Good 

Our rating of responsive stayed the same. We rated it as **good**.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service planned and provided services in a way that met the needs of local people. Patients were usually referred through their GP or local hospital, or specialist nurses. The service provided end of life care for individuals requiring care and support outside of their NHS care.

The environment was appropriate, and patient-centred with comfortable seating and access to facilities such as toilets. All of the rooms were ensuite and spacious and allowed for several family members to visit simultaneously.

There was local access to the service by car or public transport and there was dedicated car parking. The reception area was clean and tidy with access to leaflets about palliative care and fund-raising initiatives.

The service had a multi-faith quiet space that held services and prayers as well as being available for patients and relatives if they wished to use it as a space for reflection.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Care plans were in place for inpatients on the wards and community patients. These were person centred and we could see that people and their carers had had the chance to discuss them and contribute.

We observed a nurse specialist making an introductory visit to a patient. We found the nurse was professional and very respectful of being in the patient's home and gave a full overview of services available including day care services, complimentary services and information about the inpatient unit. Community nursing staff developed a plan of care collaboratively with the patient. We noted during the home visit, that comprehensive patient' assessment of their symptoms was conducted, and advice given on symptom management. The nurse

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obtained a clear picture of the patient's family and wider support network and assessed their spiritual needs. This assessment and interaction were conducted in a professional manner which demonstrated a clear understanding of the patient's needs.

The service focussed on individual needs and goals in planning patients care. Patient goals were identified, and a plan put in place to achieve the goals. For example, patients could want to achieve the goal of tackling their breathlessness, so a care plan which involved additional physiotherapy sessions would be put into place. Other goals might involve advance care planning and therefore appointments with the clinical nurse specialist to have discussions around advanced decisions, emergency decisions and preferred places of care would be arranged.

Staff monitored and reviewed the changing needs of patients through regular 'comfort rounds' and frequent medical reviews. The service had a complementary therapy team who offered a range of therapies to both patients and relatives including aromatherapy and massage.

People with a range of disabilities could access and use services on an equal basis to others. There was wheelchair and other access to those with disabilities, including those with sight and hearing impairment.

The service had arrangements to access translation services for patients. Staff we spoke with could tell us how they would access these services and provided examples of occasions that they had done so.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

The service had processes to manage admission to the service. The service had an admissions and referrals team who monitored and forwarded referrals and admissions to the appropriate service. Referrals came through from the local hospital, GP's or nurse specialists.

Referrals to the service were managed well. The hospice at home team worked to keep people at home if that was

where they wanted to be. A referral to the inpatient unit did not therefore always result in admission. People's preferences were respected and met where possible. Patients had fast track admissions 24/7, either direct from the community or transfer from hospital. We saw that patients in the hospice who wanted to return home to die were well supported to do so.

Clinical staff provided support across the in-patient and community services, the team were well placed to decide what movement was needed to take place that day and what resources could be allocated to support this. The clinical team met daily to discuss patients' care needs.

Staff discussed service provision at daily multi-disciplinary meetings. This included when appropriate patients would be discharged to their preferred place of care. During the inspection, we saw that the hospice only had eight patients on the inpatient unit, however they had 14 beds available. Managers told us that this was due to funding and staffing issues. Staff told us that on occasion, they would have a waiting list for the beds. This meant not all patients who needed admission to the hospice can be admitted.

New patients in the community were triaged and assessed within 72 hours of referral. An appointment was made for a first assessment as appropriate to the patient need. On average, 95% of patients assessed as requiring a visit were seen within this timescale, and a further 10% were assessed as not needing a visit, either because they had passed away, been admitted to the hospital or hospice, or a visit was not convenient for the patient.

The service offered a range of appointments to meet the needs of the patients who used the service. Managers told us there was mixed demand for appointment times and they would offer appointments to suit the needs of patients.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers we spoke with knew how to complain or raise concerns and felt comfortable doing so if necessary. We saw information on how to make a complaint displayed around the hospice.

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Staff told us that in the event of a patient or relative wishing to complain, they would ask the nurse in charge to speak to them to resolve the issue in the first instance and provide them with the details of the officer in charge of dealing with complaints. Staff understood the complaints process and had access to policy and procedures to guide them in managing complaints. Managers investigated complaints and identified themes and shared these in meetings. We noted that lessons were learnt on complaints investigations and outcomes. For example, we saw that a complaint about communication resulted in the staff receiving effective communication training from a company external to the hospice.

We saw documents at the service about the complaints process. These were in the reception area and the inpatient areas where people could see them. We reviewed the complaints policy and saw it was relevant, up-to-date and clearly outlined the complaints process and steps people could take if unhappy with the outcome of a complaint.

People who used the system to make a complaint or raise concerns were treated compassionately and given the help and support. Staff received specific communication training to help them respond sympathetically to people who were distressed, or who were dissatisfied with the service. Staff were expected to report and escalate any concerns so that they could be addressed promptly and to provide an opportunity for a senior member of staff to explore these with patients or families if necessary, where the concern was not resolved immediately. Staff told us in most cases, patients would raise concerns and complaints verbally to them and they would in most cases be dealt with there and then.

Are hospice services for adults well-led?

Good 

Our rating of well-led stayed the same. We rated it as **good**.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the

priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The management were very committed and passionate about patient care and a high-quality service. This was reflected in the way the team was led and kept patients at the heart of service delivery. Managers felt strongly about trusting and empowering the staff team and advocated an autonomous approach to the work undertaken. They understood the challenges the service faced, in particular, the national shortage of nurses and the impact this could have on the service.

Leaders recognised that the hospice had used the same model of delivery and management for many years, and that this required a review. Since our last inspection, leaders had developed a clinical action plan to change the way in which the hospice had been managed. This included introducing a daily MDT meeting as opposed to a weekly one, informal reflection/drop in clinics for all staff in recognition of the emotive environment they work in, breaking down cultural barriers between day and night teams including the internal rotation of staff between shifts and inpatient unit/community, changes to the IT system to allow a standardised approach to documentation, promotion of the practice development nurse, and a restructure of the clinical leadership team.

Staff told us they felt supported by the senior management team and that they were friendly and approachable. Staff felt confident in approaching them regarding issues to do with their professional or personal life.

Leaders within the service went out of their way to ensure they were visible and approachable. Staff told us that leaders from all levels within the organisation were approachable and supportive and that members of the senior leadership team could be seen regularly on the inpatient unit as well as the community and would offer support if the service was busy.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision

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and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a clear vision to offer a value-based service to meet the needs of the patients. The vision was for the hospice to 'by 2023 be a beacon of excellence delivering adult end of life and specialist palliative care and a bereavement support service for the people of Sutton and Merton. The Hospice will strive to implement best practice in all areas of care and its services, and in its business and fundraising endeavours'. All the staff we spoke with were aware of the vision and strategy of the service, and had been involved in its development

The service had an organisational objective plan for 2019/2020, which was aligned to the five-year strategic plan 2018-2023, which encompassed all its services. The service had sought the views of patients and staff when creating the plan and endeavoured to align the plan with Hospice UK guidance, national strategy and the local sustainability and transformation partnership for end of life care.

The service had plans in place to separate from The Congregation of the Daughters of the Cross of Liege, becoming its own sustainable and independent local charity from Spring 2020. Leaders told us that by securing a self-sustaining future for the organisation, they planned for the community to be able continue to access its services for years to come.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Teams worked collaboratively, and we saw examples of positive cross-team working to provide joined up care for patients. There were strong links between those working in the community and inpatient staff, meaning that patients received a seamless service. Staff told us that although some staff were apprehensive at the proposed

internal rotation, they felt it would be beneficial for inpatient staff to rotate to the community, and community staff to rotate to the inpatient unit as it would broaden their experience and skills.

The service had an in-date lone working policy. Staff and volunteers working in the community had a buddy system with another worker who would call if they were not where they were supposed to be on time. Staff wore personal safety devices when entering people's homes and could call for assistance using these discreetly if needed.

All staff we spoke with were positive about working for the hospice. They described feeling valued and supported in their role. Staff who worked remotely said they felt connected to the team and to the organisation. The service valued the contribution of its volunteers. Volunteers were recognised by the hospice and we saw many examples of volunteers being nominated for awards within the local area. One member of staff told us how she had gone from a bank healthcare assistant to an established member of staff and was being supported to commence her counsellor training. Throughout the inspection, we saw that staff assisted each other with tasks, and responded quickly to service needs.

Staff felt connected to other teams within the service and the organisation. The community nursing team told us they worked well with teams from the inpatient unit and the outpatient service and were looking forward to an even closer working relationship through the planned rotation of staff through both community and inpatient areas. We saw the service had a whistleblowing policy which was available to all staff and information on how to raise whistleblowing concerns formed part of mandatory training. Staff we spoke to knew how to raise concerns.

There was a recognition of the importance of ensuring patients received a good end of life care experience across all staff groups and services. Staff were engaged with the hospice and proud of the care and treatment they provided for patients.

The culture of the service encouraged openness and honesty. We reviewed incident and investigation reports and saw that the service applied Duty of candour appropriately. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify

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patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke to were aware of the term and could give examples of when the Duty of candour would be applied.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

During the inspection, we saw that the governance structure enabled issues from team meetings to be escalated to the senior management, and in turn, information could be passed to the care team meetings.

The service had a clear governance process to continually improve the quality of service provided, including the introduction of the clinical action plan. Staff understood their roles and responsibilities in relation to governance. Governance arrangements were clear and appropriate to the size of the service.

The service had a strong governance structure that supported the sharing of information from frontline staff to senior managers and trustees. The hospice held monthly team meetings. These meetings in turn fed into the service's board meetings. The board meetings were attended by senior members of staff in the organisation including the chair, trustees, service leads, head of governance and head of finance.

The service had established good governance systems to assess, monitor and improve the quality and safety of the service people received from the hospice. This included a quality improvement committee that met every two months, which was attended by various senior managers and heads of departments. In addition to this, there were bi-weekly senior management and monthly department meetings which steered the hospice's approach to staff training and education, health and safety, and infection control. These groups had standing items on their agendas and regularly reviewed clinical incidents, complaints, policies and procedures, patient information, patient feedback and financial monitoring.

There were clear lines of accountability in the service. The service had nominated leads in areas such as safeguarding and infection prevention and control. These leads reported on these areas during board meetings.

There was also a rolling programme of audits being undertaken that covered high risk areas including pressure ulcer prevention and management, patient record keeping, pain management, and dignity in the dying stage.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had a business continuity plan that ensured continuity of care in an emergency. We saw the plan covered various issues including loss of access to paper records, loss of electricity, loss of water supply, and fire.

We saw that the service had a risk register that included clinical risks, as well as full charity risks which included fundraising. The senior managers described the main risks to the service which we noted were on the risk register. This included staffing and funding. Mitigating actions and responsible person in charge of each risk had been clearly noted, along with review dates. We saw that all risks on the risk register were rated according to severity rating and were regularly reviewed.

Staff understood what their key risks to the service were and there was good oversight of them. Feedback from people who used the services and those close to them was regularly discussed at MDT meetings and quality improvement meetings. The service reviewed compliments, complaints and any concerns that had arisen. Concerns were discussed by the clinical lead and actions identified and assigned to senior staff members.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, to understand performance, make decisions and improvements,

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however information was not always easily accessible. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

We saw that information governance training formed part of the mandatory training programme for all employees of the service. Staff we spoke with understood their responsibilities regarding information management.

Staff had access to technology to help document patient care needs and outcomes, this included an electronic system, mobile computers and electronic care records. The IT system enabled sharing of records with community teams, which facilitated joined up care. However we observed that staff had difficulty navigating the electronic system, and that it was difficult for them to find information quickly when asked.

All IT systems were protected by security measures. All staff, including bank staff had individual log on details and access to patient information was restricted depending on staff's role. During the inspection, we saw that computer screens were locked when staff were not sitting at their desks. This prevented data protection breaches and maintained confidentiality.

In the last 12 months, the hospice had submitted all required notifications to the Care Quality Commission without delay.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service engaged well with patients, staff, volunteers and the public and local organisations to plan and manage appropriate services and collaborated with partner agencies effectively. The service ran a patient survey for service users to give their feedback about their experience. We saw the results from these feedback were overwhelmingly positive. We saw that the service responded to any comments made to improve the quality of the experience. For example, patients in the community had voiced concerns at having a named

nurse, meaning they only saw that nurse and not other staff. The service has now changed the way the community nurses work and they now work as teams. This means patients now see a variety of nursing staff.

During our inspection, we saw the hospice had strong links with the local community. Approximately 600 volunteers supported the hospice in various ways. This included working in the St Raphael's charity shops, or directly supporting inpatients who stayed at the hospice, or through their various community supporter groups. For example, volunteers worked in the shops, restaurant, on reception, in the day centre, on the ward and transporting people to the hospice. Some were also involved in events to raise funds for the hospice. For example, one group of volunteers we met in the restaurant were regular knitters, crocheting various ornaments and items throughout the year to raise money for the hospice.

There was regular communication with staff via the staff newsletter, team meetings, and the intranet page. The service held various staff awards to recognise staff contribution included long service awards for long serving staff members. The hospice sought out staff opinion through the use of a staff survey.

The service ran a patient forum and a family and friends involvement group both of which were ways for people to have a way to help improve the quality of the existing services and be involved in the discussion about the development of future services.

The hospice worked in close partnership with external community professionals. Members of the hospice at home team told us they had good working relationships with other external community professionals also involved in their patient care, which often included a persons GP, district nurses, a night nurses working for a charity for people with terminal illnesses and social service care managers. This ensured people received consistent and co-ordinated care and support at home.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

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The service was committed to improving services by learning from when things went well or not so well and promoted training and innovation.

The service was committed to providing regular training opportunities to staff. We saw that as part of the clinical action plan. The service had increased the establishment of band 5 and 6 nurses to rotate between departments. These were developmental roles and allowed staff members to rotate between all departments following a structured development program, with structured competencies and timeframes. This also allowed junior nurses to support complex visits in the community.

The hospice kept up to date with good practice guidelines and attended various groups to develop and

share best practice which included being active members of the Social Care Institute for Excellence (SCIE); Quality and Service Improvement Network Group (QSING); Hospice UK; the South West London Hospice Collaborative Group; and the medicines management committee for Sutton and Merton.

The hospice was responsive to national strategies and also had good links with the National Institute for Health and Care Excellence (NICE), General Medical Council (GMC), Nursing and Midwifery Council (NMC) and Medical Student Education programme. Managers told us these links had helped the hospice develop specific study days for the specialism in the education department.

Outstanding practice and areas for improvement

Outstanding practice

- People's individual needs and preferences were central to the delivery of tailored services. The staff were exceptionally caring, compassionate and empathetic towards both the patient and their relatives. For example, the service arranged for the family room to be converted to a 'cinema' to allow a patient and their family to watch a movie together and arranged for the family room to be converted into a 'restaurant', so the same patient and their spouse could have a 'date night' together.
- The service had hospice biographers, who alongside the patients would write patient biographies that they can leave as a memoir of their life for their family and friends.

Areas for improvement

Action the provider SHOULD take to improve

The provider should ensure that the electronic notes system is easy to navigate, allowing staff to quickly and easily access patient information including risk assessments.

The hospice should replace the carpet in the inpatient unit to prevent slips trips and falls from occurring.