

Sue Ryder - Thorpe Hall

Quality Report

Thorpe Road
Longthorpe
Peterborough
Cambridge
PE3 6LW

Tel: 01733 225900

Website: www.suerydercare.org

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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

Outstanding



Are services safe?

Good



Are services effective?

Good



Are services caring?

Outstanding



Are services responsive?

Outstanding



Are services well-led?

Outstanding



Summary of findings

Letter from the Chief Inspector of Hospitals

Sue Ryder – Thorpe Hall is operated by Sue Ryder, a national charitable organisation which specialises in providing palliative and neurological care to people living with life-limiting conditions. The hospice has 20 inpatient beds. Facilities include an inpatient unit, hospice at home service, day services and family and bereavement support services.

The hospice provides end of life and palliative care for adults. We inspected all services provided.

We inspected this service using our comprehensive inspection methodology. We carried out a short notice announced inspection on 10 December 2019, along with an unannounced visit to the hospice on 18 December 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 hospice improved. We rated it as **Outstanding** overall.

We found areas of outstanding practice:

- Staff treated patients and their families with compassion and kindness, respected their dignity and privacy, and went above and beyond expectations to meet their individual needs and wishes. Staff did all they could to support the emotional needs of patients, families and carers to minimise their distress. Staff helped patients live every day to the fullest.
- Services were delivered in a way to ensure flexibility, choice and continuity of care and were tailored to meet patients' individual needs and wishes. The service planned and provided care in a way that fully met the needs of local people and the communities served. It also worked proactively with others in the wider system and local organisations to plan care and improve services.
- It was easy for people to give feedback. Concerns and complaints were taken seriously and investigated, and improvements were made in response to feedback where possible. Patients could access services when they needed them.
- Leaders ran services well and supported staff to develop their skills. Staff understood the vision and values, and how to apply them in their work. Staff were motivated to provide the best care they could for their patients. There was a common focus on improving the quality and sustainability of care and people's experiences. Staff were proud to work at the service and felt respected, supported and valued. Leaders operated effective governance processes and staff at all levels were clear about their roles and accountabilities. The service engaged well with patients, staff and the local community.

We found areas of good practice:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

Summary of findings

- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

We found areas of practice that require improvement:

- Patients' preferred place of care and preferred place of death was not consistently recorded on the electronic system.

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

Heidi Smoult

Deputy Chief Inspector of Hospitals, on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

**Hospice
services for
adults**

Rating

Outstanding



Summary of each main service

We rated this service as outstanding for caring, responsive and well-led, and good for safe and effective.

Summary of findings

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Outstanding



Sue Ryder - Thorpe Hall

Services we looked at

Hospice services for adults

Summary of this inspection

Background to Sue Ryder - Thorpe Hall

Sue Ryder – Thorpe Hall is operated by Sue Ryder, a national charitable organisation which specialises in providing palliative and neurological care to people living with life-limiting conditions. The hospice is located in Longthorpe, Peterborough. It primarily serves the communities of Cambridgeshire, Peterborough and South Lincolnshire.

The hospice has had a registered manager in post since 1 October 2010. At the time of the inspection, the appointed manager had been registered with the CQC since 4 December 2014.

The registered manager was the hospice director.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in end of life and palliative care. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Information about Sue Ryder - Thorpe Hall

The hospice provides inpatient, day services and community-based end of life and palliative care services. Palliative care is the care and support given to people living with life-limiting conditions, for example, cancer, heart failure and lung disease. It aims to give people the best quality of life possible by managing pain and other symptoms while someone is living with a life-limiting condition.

The inpatient unit has 20 beds. All rooms are single rooms which have ensuite facilities. Day services include physiotherapy, occupational therapy and complementary therapies. The hospice at home service provides palliative care for patients who choose to receive care at home. The family and bereavement support service provides bereavement counselling and support for patients and their families.

The hospice accepts both male and female adult patients.

The hospice is registered to provide the following regulated activities:

- Diagnostic and screening procedures

- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

During the inspection, we inspected the inpatient unit, hospice at home service, day services and the family and bereavement support service. We spoke with 42 staff including registered nurses, health care assistants, medical staff, volunteers and senior managers. We spoke with nine patients and one relative. We observed the environment and care provided to patients and one home visit. We reviewed five patient records and eight prescription charts. We also reviewed information that we held about the hospice and information requested from the hospice, including performance data, policies and meeting minutes.

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 three times, and the most recent inspection took place in May 2015, which found that the hospice was

Summary of this inspection

meeting all standards of quality and safety it was inspected against. We rated the hospice good for safe, effective, caring, responsive and well-led. The hospice was rated good overall.

Activity (August 2018 to July 2019)

- In the reporting period August 2018 to July 2019, 364 patients were treated for palliative care. Of these, 102 (28%) were aged between 18 and 65 years, and 262 (72%) were aged over 65 years.

Track record on safety:

- Zero Never events
- Two serious incidents

- One incidence of healthcare associated MRSA
- Zero incidences of healthcare associated Clostridium difficile (C. diff)
- One complaint

Services provided at the hospice under service level agreement:

- Pharmacy and pathology
- Psychology
- Laundry
- Interpreting services

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:

- 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 managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.
- 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 up-to-date 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 most incidents and near misses appropriately. Managers investigated incidents and shared lessons learned with the whole team and 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.

Good



Are services effective?

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

Good



Summary of this inspection

- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs. They used special feeding and hydration techniques when necessary.
- 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 health and social care 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 to help them live well until they died.
- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions.

Are services caring?

Our rating of caring improved. We rated it as **Outstanding** because:

- Staff treated patients and their families with compassion and kindness, respected their privacy and dignity, and went above and beyond what would have been expected, to meet their individual needs and wishes. Patients and their families were truly respected and valued as individuals by an exceptional service.
- Staff were devoted to doing all they could to support the emotional needs of patients, families and carers to minimise their distress. Patients emotional and social needs were seen as being as important as their physical needs.
- Staff supported and involved patients, families and carers to understand their condition and ensure they were active partners in their care and treatment. Staff helped patients live every day to the fullest.

Outstanding



Summary of this inspection

Are services responsive?

Our rating of responsive improved. We rated it as **Outstanding** because:

- Services were delivered in a way to ensure flexibility, choice and continuity of care. The service planned and provided care in a way that fully met the needs of local people and the communities served. It also worked proactively with others in the wider system and local organisations to plan care and improve services.
- Services were tailored to meet the needs of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- Patients could access the service when they needed it.
- 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.

However:

- Patients' preferred place of care and preferred place of death was not consistently recorded on the electronic system.

Outstanding



Are services well-led?

Our rating of well-led improved. We rated it as **Outstanding** 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 both patients and staff. They supported staff to develop their skills and take on more senior roles.
- 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 strategy was fully aligned with plans in the wider health economy and there was a demonstrated commitment to system-wide collaboration and leadership.
- Staff were motivated to provide the best care they could for their patients. There was a common focus on improving the quality and sustainability of care and people's experiences. Staff felt respected, supported and valued. The service had an open culture where patients, their families and staff could raise concerns without fear.

Outstanding











Summary of this inspection

- 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.
- The service invested in best practice information systems. Staff could mostly 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, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- 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	 Outstanding	 Outstanding	 Outstanding	 Outstanding
Overall	Good	Good	 Outstanding	 Outstanding	 Outstanding	 Outstanding



Hospice services for adults

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

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 was provided by a combination of e-learning and face to face training, which included basic life support, information governance, infection control and safeguarding. Staff we spoke with understood the importance of keeping up to date with their mandatory training. Staff described training as thorough and relevant to their roles.

At the time of our inspection 91% of staff were up to date with their mandatory training. This met the provider's target of 90% compliance.

The practice educator had oversight of mandatory training for all staff. Alerts were automatically generated for any members of staff who were not compliant with their mandatory training. Managers received regular reports about mandatory training compliance. This ensured they had oversight of staff compliance in their areas, and could address any compliance issues if needed.

The practice educator worked closely with managers to ensure training needs were met. Staffing rotas were planned in advance to ensure staff were able to attend the training that they were required to complete.

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 service had a safeguarding adults policy which included guidance for staff on their responsibilities and safeguarding processes. We reviewed the policy which contained clear guidance on the process staff should follow if they suspected abuse or harm and was based on national guidance. It was dated May 2019 and had a review date of May 2022. Safeguarding information was displayed in all locations we visited during the inspection. Staff could also access safeguarding resources through the provider's intranet.

The service did not deliver care to children, however, all staff completed training in safeguarding children. Staff were required to complete safeguarding adults and children training at level two. Information provided following our inspection indicated that 91% of staff were compliant with this training overall.

Staff we spoke with demonstrated that they knew how to identify adults and children at risk of harm. Staff gave appropriate examples where they had raised safeguarding concerns, for example when financial abuse was suspected. Staff could explain the process of safeguarding a patient which was in line with the service's policy.

The safeguarding lead for the service was the head of clinical services. This person was trained to safeguarding level three, which was in line with national safeguarding guidelines. The NHS England intercollegiate document, Adult Safeguarding: Roles and competencies for



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healthcare staff 2018, stated that registered health care staff who engaged in assessing, planning, intervening and evaluating the needs of adults where there were safeguarding concerns were required to undertake level three safeguarding training. However, the safeguarding lead was on long term sick leave at the time of our inspection. Information provided by the service following our inspection stated that the inpatient unit manager and practice educator would receive level three safeguarding training in January 2020.

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.

Infection control training formed part of the mandatory training programme for staff. Data provided by the service showed that 95% of staff had completed infection control training.

There were systems in place to regularly monitor standards of cleanliness. The most recent infection prevention and control (IPC) audit for 2018-2019 assessed policy compliance with legislation and national guidance, use of personal protective equipment (PPE), hand decontamination, sharps and waste disposal and staff training, for example. Results of the IPC audit showed overall compliance was 95% against a target of 90%. There was an action plan in place to improve future audit performance, and all actions were assigned to individuals with due dates.

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. The hospice had housekeeping staff who were responsible for cleaning patient and public areas, in accordance with daily and weekly checklists. The daily cleaning checklists were completed in all of the records we reviewed.

Staff cleaned equipment after patient contact and labelled equipment to show when this had last been done. Staff labelled equipment with 'I am clean' stickers after cleaning which showed the last date it was cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed

staff using hand sanitiser upon entrance to the inpatient unit. We observed staff washing their hands before and after patient contact, and they adhered to the 'bare below the elbow' policy. PPE was readily available.

The service carried out audits to monitor staff compliance with hand hygiene. We reviewed audit results from March 2019, July 2019, September 2019 and November 2019 which demonstrated that hand hygiene compliance was 100%.

Effective measures were in place to ensure the health and safety of individuals who came into contact with a deceased person's body after death. For example, staff used PPE. Staff we spoke with were aware of the measures in place and could describe how they cared for patients after death by performing last offices. The hospice was trialling the use of a cold blanket which meant patients could remain in their rooms after death until they were collected by funeral directors. There was a checklist for staff to complete during the use of the cold blankets and there was clear pictorial and written guidance for staff on how to use them.

The hospice had a designated IPC lead who was available to provide advice and support to staff. The IPC lead was responsible for maintaining their own professional development in relation to infection control. The IPC lead was a registered nurse who had protected time to carry out IPC audits and deliver IPC training to staff members.

From August 2018 to July 2019, the hospice reported one incidence of healthcare associated MRSA. This was reported as a patient was admitted to the hospice who already had MRSA. No instances of *Clostridium difficile* (a bacterium which can infect the bowel) were reported during that time frame.

Environment and equipment

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

Patients could reach call bells and we observed that staff responded quickly when called.

The design of the environment followed national guidance. Access to the inpatient unit was monitored by reception staff during the day and was accessed via staff



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swipe cards out of hours in order to protect patients and prevent unauthorised access. Day patients and visitors were required to sign in and out when entering and leaving at the hospice reception.

Staff carried out daily safety checks of specialist equipment, in line with the service's policy. We found that consumable items were well organised, clean and with sealed packaging.

Effective processes were in place to ensure equipment was well maintained and fit for purpose. The hospice held a record of all equipment which included when servicing was required. All electrical equipment we reviewed during the inspection had been serviced when required.

Staff had access to syringe drivers to provide patients with medicines to manage their symptoms. The service used syringe drivers that met national safety standards. We checked two syringe drivers during our inspection, which were within date of their next electrical safety service. Information provided following inspection showed that all syringe drivers were within date of servicing. Staff we spoke with told us that they could easily access syringe drivers when they needed them.

We checked a sample of consumable items for expiration dates and all were in-date. Store rooms were tidy and well organised.

Staff disposed of clinical waste safely. We observed that waste was segregated appropriately between clinical and non-clinical waste. Sharps containers were clean, labelled appropriately and not overfilled.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff demonstrated a person-centred approach to planning and delivery of care which kept patients as safe as possible and recognised patient choice. Staff completed 'What matters to me' forms which included patient preferences and dislikes, how they like to be known and any specific goals they wished to achieve.

Staff completed risk assessments for each patient on admission and updated them when necessary and used

recognised tools. We reviewed five patient records and found that comprehensive risk assessments were carried out. These included risk assessments for the use of bed rails, skin integrity, falls and nutrition and hydration. Staff used recognised tools including Waterlow, a tool used to identify the risk of pressure ulcers. The malnutrition universal screening tool (MUST) was used to assess nutritional needs.

Staff managed increased risks experienced by patients at the end of their lives. The service focussed on falls prevention and there was a nominated falls lead appointed each day within the inpatient unit. Bed rails were used following risk assessment, where appropriate. Staff were required to complete an outcome following completion of a risk assessment for bed rails. This included whether bed rails were to be used, any additional risks to the patient, whether the patient's family were in agreement with the use of bed rails and compliance with bed rail standards. In the event of a patient fall, staff completed a post fall assessment record and a neurological observations chart to be used following a head injury.

Handovers included all necessary key information to keep patients safe. A nursing handover took place at the change of each shift. A multi-disciplinary handover took place daily for medical and therapy staff on the inpatient unit. The team prioritised and identified particular tasks to be carried out. Handovers were comprehensive and included the emotional and psychological needs of patients.

Staff ensured they identified any increased needs. The service used NEWS2 (national early warning score), a tool used to identify, monitor and manage deteriorating patients. We reviewed five sets of patient records during the inspection and found NEWS2 charts were completed appropriately with scores calculated correctly and escalated where needed.

Staff completed intentional care rounding assessments. Intentional care rounding is a structured process where staff carry out regular checks with individual patients at set intervals. Tasks that were carried out during these checks included assessing the patient's comfort, personal care such as mouth care, bathing and pressure area care, as well as checking of pressure equipment.

Nurse and medical staffing



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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.

Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment. Managers monitored skill mix and reviewed available staff in comparison with demand and planned admissions. Managers were planning to use a recognised tool for planning staffing levels and skill mix which had been successfully piloted within the service. The tool reviewed staff skills along with hospice capacity and patient complexity.

We observed the hospice had enough staff of an appropriate skill mix, to keep patients safe and provide effective care and treatment on the days of our inspection. A registered nurse was responsible for coordinating admissions and discharges within the inpatient unit. This meant that all other staff could focus their time on caring for patients. Some experienced staff we spoke with told us that a number of new staff members had recently joined the team. They told us this impacted the team at times because the new staff needed guidance, which added more pressure to the experienced staff to carry out tasks.

Medical staff were on site from 9am to 7pm during week days and from 9am to 5pm at weekends. There was medical cover out of hours provided by a local clinical commissioning group (CCG). The service had no medical staff vacancies at the time of our inspection.

The service had 2.4 whole time equivalent (WTE) nursing vacancies, however two nurses had been recruited and were due to commence their posts shortly, leaving the nursing vacancies at 0.4 WTE.

At the time of our inspection, the service was advertising for a deputy director and was in the process of interviewing for a head of family support services.

Arrangements for using bank, agency and locum staff kept people safe. Managers told us that actual staff numbers generally matched planned numbers, however any short fall was filled by bank and agency staff. Bank

staff were used in preference to agency staff, and the agency staff used had experience in palliative care. Bank and agency staff completed a full induction. Bank staff were also required to undertake the same mandatory training as substantive staff.

Arrangements for handovers and shift changes ensured that people were safe. A nursing handover took place at the change of each shift, as well as a daily multidisciplinary handover. We observed both types of handover which were comprehensive, detailed and contained personalised discussions about patients, their needs and wishes.

Records

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

Patient records were comprehensive, and all staff accessed them easily. We reviewed five patient records during the inspection. Records were personalised, complete and noted multi-disciplinary team involvement with other healthcare professionals where relevant. Risk assessments had been completed where required. For example, falls assessments and corresponding care plans had been completed where applicable in each patient record we reviewed.

The service audited care records for completion across the service. We reviewed the palliative documentation audit 2019 to 2020. The audit included the completion of risk assessments and care plans, whether preferred place of care was recorded, whether consent to treatment was obtained and whether information regarding mental capacity had been completed. The results of the audit showed 96% compliance overall. There was an action plan in place with named individuals responsible for achieving them with completion dates for the actions.

Staff could share details of patient care with other professionals and agencies. The electronic patient record system used was the same system used by local GPs, district nurses and Macmillan cancer support nurses. This meant staff had immediate access to up-to-date patient information.

We observed that records were stored securely. Staff used key cards to access the electronic patient record system which was password protected. Paper records were



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stored securely in locked cabinets close to the inpatient unit reception desk. Consent to storing and sharing patient information was obtained in the records we reviewed.

Care rounding forms were used to assess and care for patients based on their individual needs. The forms were colour coded and personalised. Green comfort rounding sheets were used for those patients who were independent or required minimal assistance. Orange comfort rounding was used for patients who needed some assistance, such as reminding to change position every four to six hours. Red comfort rounding forms were used for those who were nursed in their beds and required full assistance.

The service used a combination of paper based and electronic records on the inpatient unit. This meant it may have been difficult for unfamiliar staff to be able to find certain information. We also found some risk assessments were not linked to care plans on the electronic system, although the documentation had been completed. When we returned for the unannounced inspection, the service had devised a full action plan for patient records. Actions included introducing short training sessions to ensure staff were up to date with systems which would cover linking risk assessments to care plans. The service developed a list of where all patient records could be found. A documentation working group was set up with the aim to transition from using paper records to electronic patient records only.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The service had a contract in place that was funded by the local clinical commissioning group (CCG) for a local acute hospital to provide all pharmacy supplies for the hospice. Part of the contract included a weekly visit from a pharmacist to provide advice and support to staff regarding the use of palliative care drugs. The pharmacist also reviewed patient drug charts, provided advice on doses, interactions and contraindications of prescribed medicines, as well as

quarterly controlled drug audits with the accountable officer. Medicine stocks were checked and ordered by the nursing staff. Orders were completed twice a week and staff could review what had already been ordered.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. All medicines were kept in a locked cupboard in a locked clinic room on the inpatient unit. Medicines that needed to be kept below a certain temperature were stored in a locked fridge. The treatment room where medicines were stored was air-conditioned. This meant the temperature was maintained within the recommended range (below 25°C). We saw storage temperatures were checked daily to ensure medicines were effective and safe for patient use. We reviewed checks from 1 October 2019 to 24 November 2019 and found that all checks were completed daily with no omissions. All temperatures documented were within the required range.

Staff followed current national practice to check patients had the correct medicines. All medicines and doses were within British National Formulary (BNF) ranges. Patients receiving end of life care were prescribed anticipatory medicines to manage symptoms that may be present at the end of life. Anticipatory medicines are prescribed to be given when needed, rather than on a regular basis. Medicines were prescribed in advance to ensure that symptoms such as pain, agitation and nausea could be managed. There was information available to staff which provided guidance on the prescribing of anticipatory medicines. Staff were aware of the guidance and knew where to access it.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We reviewed eight prescription cards. Where appropriate, it was evidenced that medical staff stopped non-palliative medicines aimed at prolonging life following a medical review. This is considered good practice by the National Institute for Health and Care Excellence (NICE).

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff knew how to report medicine errors or incidents and we saw these were investigated and learning was shared with all relevant staff. There was



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a process in place for medicines to be checked whereby staff should not be disturbed or spoken to while they were checking medicines. This reduced the risk of medicine errors.

Controlled drugs were frequently used to manage patients' pain. The hospice permitted single nurse administered controlled drugs (SNAD) to ensure patients received them promptly when needed. Staff had to be signed off as competent before they were able to administer medicines in this way. The SNAD competency assessment rate was 100%, staff were trained and reassessed in accordance with the service's local policy.

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.

All staff knew what incidents to report and how to report them. Staff understood their responsibilities to raise concerns and report them using the trust's electronic reporting system. Staff could describe the types of incidents that required reporting. There were processes in place for investigating incidents and staff informed us that feedback was shared by managers. Following incidents, staff told us that learning from incidents was shared in clinical update newsletters, via email and in handovers.

Staff reported all incidents that they should report. We saw incidents were documented appropriately when we reviewed patient records. For example, we found that a patient had a fall which had been recorded as an incident.

Staff understood the duty of candour. The duty of candour is a statutory duty to be open and honest when something goes wrong that appears to have caused or could lead to significant harm in the future. Staff were open and transparent, and gave patients and families a full explanation if and when things went wrong. A staff member described a recent medicine incident and was

able to explain the actions taken and the learning that was identified following the incident. The staff member described the actions taken to ensure the duty of candour was complied with. The patient's family were met with in person to discuss the incident.

Managers investigated incidents thoroughly. Incidents reported were reviewed daily and investigations were initiated where required to identify any actions needed to address the incident and minimise recurrence. Incidents reported were also reviewed by the practice educator who was able to identify trends and assess whether there were any training needs among staff.

From December 2018 to November 2019, the hospice reported no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. For the same reporting period, the hospice reported one serious incident which was related to a patient fall.

From December 2018 to November 2019, the hospice reported 250 incidents. 97 of those were related to medicines management, 63 were related to falls and 90 were in relation to pressure ulcers. Incidents were graded as having caused no, low, moderate, severe harm or death. Most incidents reported within the service were graded as having caused no or low harm, two falls and three pressure ulcer related incidents graded as moderate harm.

There was evidence that changes had been made as a result of feedback. One example of this was the development of different signs to identify who was in the room or prevent people from walking in unnecessarily. For example, a swan symbol was used to indicate that someone had died. We saw the signs hanging outside of patient's rooms and staff were able to select the appropriate card.

Safety Thermometer (or equivalent)

The service used monitoring results to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Staff monitored safety performance to indicate how safe the service was in providing harm free care. The



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prevalence of patient harm because of pressure ulcers and healthcare associated infections was monitored and reported monthly. From November 2018 to October 2019, the service reported 15 hospice acquired pressure ulcers, zero cases of healthcare associated *Clostridium difficile* (C. diff) and one incidence of healthcare associated MRSA, which the patient already had when they were admitted. This information was monitored by managers and was reported monthly in the integrated quality and performance report.

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 followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. For example, we reviewed the resuscitation policy document. The policy was version controlled, ratified and within date for review which was due in July 2020. The policy was based on guidelines produced by the Resuscitation Council (UK). Staff could easily access policies, guidelines and pathways through the hospice's intranet. Staff were informed of updated guidance through emails and team meetings.

There was a holistic approach to assessing, planning and delivering care and treatment to all people who used services. Care of patients in the last days and hours of life was delivered in accordance with the five priorities for care of the dying person. We found all five priorities (recognition of dying, sensitive and effective communication, involvement in decisions, support needs being met and individualised care plans) were met. End of life care plans were developed following discussions with the patient and their family or carers. They included evidence of communication with the patient and family,

discussions about symptom management, psychological and spiritual support needs, as well as nutrition and hydration. Care plans were completed in accordance with the Leadership Alliance for the Care of Dying People: A national framework for local action 2015-2020.

Staff completed a recommended summary plan for emergency care and treatment (ReSPECT), where relevant, to guide decision making in the event of an emergency. ReSPECT forms were completed following discussion with patients and their relatives, and included decision making surrounding whether to attempt cardio-pulmonary resuscitation (CPR). This was in line with national guidance from the Resuscitation Council (UK).

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed this during a nursing handover. Nursing staff conducted handovers twice a day, and we observed that staff included the views and psychological or emotional needs of patients and their families in their discussions. We observed discussions surrounding patients' anxiety and embarrassment, and methods of supporting those patients.

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.

Staff used appropriate tools to assess the nutrition and hydration needs of people who are approaching the end of life. Staff assessed patients' nutritional needs on admission using the malnutrition universal screening tool (MUST). MUST is a nationally recognised screening tool used to assess and monitor patients' nutritional needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff we spoke to demonstrated their understanding of the importance of nutrition and hydration in end of life care. Staff encouraged patients to eat and drink as and when they could and for as long as



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they were able to in their last days of life. Throughout our inspection, we noted that staff ensured patients had drinks within easy reach and routinely offered them fluids during the day.

The service had a guide for patients who were on a fluid balance chart or restricted fluids so they could understand how much fluid was in each container they may use, such as a mug, glass or beaker.

New evidence-based techniques were used to support the delivery of high-quality care. The service collaborated with external palliative care staff to make improvements in nutrition for patients. For example, they introduced smaller plate sizes to make meals feel more manageable. The service also used moulds so that pureed food was presented in the shape of the item to make it more appealing. For example, pureed carrots were presented in the shape of a carrot for those patients who required that type of specialised diet.

Staff provided support and advice to families of patients nearing the end of life with limited or no oral intake, which included oral health. Staff undertook daily oral care assessments to ensure patient comfort and guidance was available for staff to follow.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Staff made external referrals to access these services when required.

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. Staff asked patients to evaluate the effectiveness of their pain relief by answering whether it successfully managed their pain. Patients were asked if the pain relief was effective, partially effective or ineffective. Staff asked patients to numerically score their pain on a scale of one to 10. The service used the Abbey pain scale to assess pain in non-verbal patients.

Patients reported that they received pain relief soon after requesting it. Patients told us staff responded quickly to any request for pain relief and told us that staff discussed it with them. The hospice permitted single nurse administered controlled drugs to ensure patients received pain relief promptly when needed.

Staff prescribed, administered and recorded all pain relief accurately. We reviewed eight medication administration records. Where applicable, anticipatory medicines were prescribed in accordance with NICE guidelines. Anticipatory medicines are those that are prescribed for use on an 'as required' basis to manage common symptoms that can occur at the end of life. Where appropriate, patients had a syringe driver, which delivered measured doses of medicines over a given period of time.

Patients being cared for at home had their pain managed by GPs, district nurses and specialist nurses. Hospice at home staff monitored patients' pain levels during their visits and escalated any concerns to the district nurse service for review.

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 had a clear approach to monitoring, auditing and benchmarking the quality of the services and the outcomes for patients receiving care and treatment. The service had a programme of local audits in place. One audit completed annually was the palliative pressure ulcer audit. We reviewed the audits for 2018-2019 and 2019-2020. Overall compliance for the 2018-2019 audit was 95%, and overall compliance for the 2019-2020 audit was 93%. Both audits scored above the service target of 90%. Compliance with prevention and recording and reporting were the areas that deteriorated in the 2019-2020 audit in comparison to the previous audit. All other areas, such as risk assessments, recognition, management and service user involvement either stayed the same or improved in comparison to the 2018-2019 audit. Both audits had action plans in place to further improve outcomes for patients. Actions were assigned to individuals with completion dates.



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The service used tools to improve patient outcome measures. The service used the Australia-modified Karnofsky performance scale (AkPs), which is a measure of patients' overall performance status or ability to perform activities of daily living. Staff told us this was discussed in handover and multi-disciplinary team meetings. We saw information about this tool on display in the handover room during our inspection. Staff used this tool to plan care, treatment and support to meet the needs of patients. The inpatient unit manager told us that the service was in the process of planning to introduce Outcome Assessment and Complexity Collaborative (OACC) scores, which is used to assess what care matters most to patients and their relatives at the end of life. There was a project plan to align all hospices under the same provider by ensuring they used the same outcome tools.

The service reported outcome data to the local clinical commissioning group (CCG). Managers completed and updated a quality dashboard. The information reported to the CCG included training, medicines management, patient experience, workforce and serious incident management.

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.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. We reviewed four staff files and found they contained relevant information to demonstrate staff suitability and competence for their roles, including up-to-date disclosure and barring service (DBS) checks and evidence of professional registration, where applicable. Managers supported staff to complete revalidation with their professional body. Registered nurses completed annual medicines management training and a practical competency assessment, including drug calculations.

Staff completed training appropriate to their role in relation to end of life care. For example, training was provided in advance care planning, recognising a dying patient and having difficult conversations.

Managers gave all new staff a full induction before they started work. This included bank staff and volunteers.

Staff we spoke with told us that the induction was comprehensive and relevant to their role. New members of nursing staff worked in a supernumerary capacity for the first six weeks of their employment and underwent a preceptorship programme.

Managers supported staff development through annual appraisals. All clinical staff, including medical staff were 100% up to date with their appraisals. 60% of non-clinical staff were up to date with their appraisals. Staff we spoke with told us that they had completed their appraisals and found the process useful. The continuing development of staff's skills, competence and knowledge was recognised as being integral to ensuring high-quality care. Staff informed us that they were supported to undertake additional training if they identified any specialist interests. For example, three staff members were trained in tracheostomy at a local acute hospital.

Volunteers were used by the service and were trained and supported for the roles they undertook. They were provided with training, such as the trust's mandatory training programme.

Staff were offered regular group supervision with the psychologist. One to one sessions could be requested if required. Staff we spoke with told us that they could openly speak with their colleagues and manager if they required support or guidance.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. A full multidisciplinary team meeting took place on a weekly basis. All necessary staff were involved in assessing, planning and delivering patient care and treatment. We observed the multidisciplinary handover and ward round. This was attended by the medical team, nursing staff and a physiotherapist. Each patient was discussed in detail, with care and treatment planned holistically in accordance with their wishes.

Staff worked across health care disciplines and with other agencies when required to care for patients. The service provided a hospice at home service. The staff working in this service worked in partnership with other health and



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social care professionals, providing support in managing patients' symptoms and offering emotional support. Staff worked closely with other care providers, including community services and hospital staff to support patients to have a successful transition when they were admitted to the service and when they were transferred home.

Staff referred patients to allied health professionals such as the occupational therapist and physiotherapist to ensure that their individual needs were met. Nursing, medical staff, the therapy team and services across the hospice worked together well to deliver care and treatment in a multidisciplinary way for patients who were in receipt of end of life care. Patient records demonstrated an integrated multidisciplinary approach towards meeting patient needs.

Seven-day services

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

The inpatient unit operated 24 hours a day, seven days a week to provide care and support to patients when they needed it. The service had an open visiting policy so relatives and carers could visit at any time.

The medical team was available on site Monday to Friday if staff needed to contact them for support. An on-call consultant could be contacted out of hours for advice if required.

The hospice at home service was available seven days a week. The service could provide up to three home visits per day if the patient lived within the local area. It was possible to arrange night visits which were provided by other local hospice providers.

Health promotion

Staff gave patients practical support to help them live well until they died.

Staff monitored the wellbeing of patients and took appropriate action to promote health and wellbeing. We saw from reviewing patient records that emotional, spiritual and practical support was provided to patients.

The family and bereavement support services provided practical support to help patients work through difficult situations they experienced, such as explaining to family members that they were dying.

The day services empowered patients to live well by maintaining their independence, managing their conditions and sometimes carrying out activities that they did not think they would be able to do again, such as painting.

Staff also signposted carers to support networks provided by the service, such as a bereavement support group and an informal walking group for bereaved people.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and they knew who to contact for advice. The service had up-to-date policies regarding consent and the MCA 2005 which staff could access through the service's intranet. Staff we spoke with understood their roles and responsibilities regarding consent and the MCA. They understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions and following discussion with their family.

The palliative documentation audit for 2019-2020 showed that 100% of records audited included key information regarding mental capacity. During the inspection, we found that do not attempt cardio-pulmonary resuscitation (DNACPR) decisions were made appropriately and in line with national guidance in the records we reviewed.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The patient records we reviewed confirmed this. We also observed staff gaining verbal consent from patients' before they undertook interventions, such as personal care.



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Eligible staff completed training on the MCA and DoLS. At the time of our inspection, 96% of staff had completed MCA and DoLS training, which exceeded the hospice target of 90%.

Are hospice services for adults caring?

Outstanding



Our rating of caring improved. We rated it as **outstanding**.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. People were truly respected and valued as individuals, and empowered as partners in their care.

There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between patients, relatives and staff were caring, respectful and supportive. Staff recognised the importance of offering choice and enabling patients to make informed decisions. Staff we spoke with told us that not only did they get to know patients well, but they also got to know patients' relatives, so they felt that they knew and cared for them as a family. This enabled staff to provide tailored and personalised care that met the individual needs of patients.

Feedback from patients and their families was continually positive about the way staff treated them. Patients we spoke with thought that staff went the extra mile. They told us they were very happy with their care which they described as fantastic. Patients stated that they felt completely cared for and accepted. They fed back that staff did as much as they could to support patients and always respected their privacy and dignity. We read many messages of thanks from patients and relatives. One relative wrote "Thank you so much for looking after [our relative] and getting their pain under control. All the staff are excellent and so helpful. My [relative's] future looked hopeless and you have given me hope. You are all so wonderful". Another wrote "I cannot put into words the gratitude we have as a family for the care being given to our [relative]. Every single staff member has been

immense, we can't see there being a better place in the world to come for care and treatment. We all owe you a debt we can never repay. Thank you from the bottom of my heart".

Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed very caring interactions between staff and patients. Staff would hold a patient's hand and offer comfort. We observed staff comforting relatives by offering gentle physical support.

Staff recognised and respected the totality of people's needs. They always took patients' personal, cultural, social and religious needs into account, and found innovative ways to meet them. For example, staff told us that they had recently facilitated a wedding. It was facilitated in the sanctuary and staff told us they helped to add some appropriate decorations. The catering team made the wedding cake and made it blue so that it could be used as the bride's 'something blue'.

Staff consistently endeavoured to provide compassionate care tailored to patients' individual needs and wishes, particularly for those approaching the end of life. Staff wanted to make end of life care as good as it could be for the patient and their family or carers and went above and beyond to achieve this. For example, one patient stated that they were unable to join their family on a seaside trip to Blackpool, so staff recreated it within the hospice. Staff decorated the patient's room with bunting and sand. They also bought fish and chips which the patient was able to enjoy with their family. Patients who had pets were able to bring them into the hospice. Patients developed close bonds with their pets, so being able to have their pets with them had a positive impact on them.

Staff demonstrated the highest level of compassion to all those within their care. Staff described the hospice community as a family, and their support extended to everyone, whether they had directly or indirectly used their services. Staff told us they had invited the spouse of a recently deceased patient to come to the hospice for Christmas dinner so that they would not be alone.

Staff ensured that care after death included honouring the spiritual and cultural wishes of the deceased person



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and those close to them. Family members and carers were able to assist with the personal care of the body after death if they wished to do so, such as bathing and dressing.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. People's emotional and social needs were seen as being as important as their physical needs.

The service ensured that the needs of families and others important to the patients were actively explored, respected and met as far as possible, including after the person has died. The service provided family and bereavement support services for patients and their families pre and/or post bereavement. The service helped people work through feelings and situations they were experiencing or any worries they had about the future, loss or grief. Depending on the complexity of the individuals' needs, people were seen by bereavement support volunteers, counsellors or a clinical psychologist. The aims of the family and bereavement support services team were to support and advise patients and their families at an incredibly difficult time, to ease distress and enable families to understand their thoughts and feelings, and to encourage each other to discuss and share their experiences.

The service provided further support to families who were facing bereavement or who had been bereaved. The family and bereavement support service provided a bereavement support group which was held twice a month, where a member could attend for up to a year. Attendees had the opportunity to meet others who had similar experiences to offer each other support. The service also had a friendship group for people who had been bereaved to meet others for support and friendship. People often transitioned to the friendship group after a year in the bereavement support group.

Patients were supported emotionally, this including patients who did not have family, friends or carers to support them. Patients could access the family and bereavement support services if they wished. They could also access support from spiritual care services within the hospice. Spiritual care was available every day. The

service offered pastoral and religious support depending on patients' needs. The head of spiritual services described it as a huge privilege to be there to support patients when they needed it.

The service ran an annual day of remembrance, known as the 'Lights of Love' event. Families and carers were invited to attend the event to reflect and remember their loved ones and to provide emotional support. The most recent event was held in a cathedral in the local community because so many families and carers wanted to join together to participate in the event.

Staff gave patients, carers and those close to them emotional support and advice when it was required. Staff told us how a life threatening condition impacted on patients and those close to them. Staff spent time with patients and their relatives to reduce distress and answer any questions to help alleviate anxiety.

One patient that we spoke with told us that they found they lost touch with some of their friends when they became ill, which they found very isolating. The patient stated that they valued the time they had to come to the hospice and speak to others in similar situations. The had been able to form new friendships since visiting the hospice.

The service ran a wellbeing cafe on the unit for patients, relatives and staff to attend. The wellbeing café provided some structure, yet was also social and informal. It created an environment where patients supported one another through their shared experiences, and received emotional support and guidance from the staff running the sessions.

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. People's individual preferences and needs were always reflected in how care was delivered.

Staff made sure patients and those close to them understood their care and treatment and supported patients to make advanced decisions about their care, where possible. Patients we spoke with felt they had received the information they needed to understand their



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condition. One patient told us that the doctor they saw when they were first admitted spent a lot of time explaining everything to them in a way they could understand and answered all of their questions.

Patients were active partners in their care. We observed the inclusive manner in which a doctor addressed patients during a ward round. The doctor sat at the same level as the patients whilst talking to them. The doctor ensured that the patient's priorities were the priorities for their care going forward.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff always empowered people who used the service to have a voice. Staff had picture cards available to use when needed which supported patients to communicate how they were feeling, such as afraid, angry, helpless, comfortable and relieved. Patients and relatives we spoke with told us they never felt rushed whilst talking to staff, and that staff encouraged them to ask questions.

The service ensured that families could access the information they needed. Following the death of a patient, families were asked to return to the hospice the following day or shortly afterwards for a 'day after death' meeting. This enabled families to ask any questions they had surrounding the care of their loved one. Staff explained the next steps to families and arranged registrar appointments for them.

Patients and their families were encouraged to provide feedback about the service. One method of feedback was anonymous 'real time' feedback. The service ran various surveys and provided feedback cards. Feedback could also be provided via the hospice's website.

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

Outstanding



Our rating of responsive improved. We rated it as **outstanding**.

Service delivery to meet the needs of local people

Services were delivered in a way to ensure flexibility, choice and continuity of care. 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 reflected the needs of the population served and promoted flexibility, choice and continuity of care. The service provided inpatient and hospice at home palliative and end of life care. This enabled patients to choose their preferred place of care, where possible. The service also offered day services for patients living with long term conditions which supported patients to manage their conditions.

Managers planned and organised services so they met the changing needs of the local population. The service had a strategy to build on hospice care in the community. The service planned to appoint a project manager to carry out a scoping exercise to assess the need for end of life care in the community. The service planned to use findings from this exercise to help plan the expansion of community based services in the future.

The service worked closely with other organisations in the wider system to design and plan palliative and end of life care services. The hospice at home service worked with organisations across the local area to ensure people approaching the end of their lives received the care they needed to ensure they could remain in their own homes. Staff worked with district nurses, GPs and specialist Macmillan nurses. The hospice at home service offered short term nursing care, personal care and emotional support for patients with a life-limiting condition and their families.

The hospice had identified where people's needs and choices were not being met and used this to improve and develop services. Managers identified there was limited work to support young people who were transitioning from children's hospices to adult hospices. The service worked with another local hospice and a local children's hospice to help develop a transition pathway. A representative from the service attended a regional action group for transitions. The service was at the second stage of a bid for a full time transition lead to



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work across all hospices involved in the action group. The service facilitated three transition events over the last year which were; a silent disco, a parent support workshop and a Halloween event.

Facilities and premises were appropriate for the services being delivered. The hospice was situated in a peaceful location which offered free parking. The garden and sanctuary areas promoted a peaceful environment. The patient bedrooms we saw were spacious and light, and all had access to the garden from their bedrooms. The inpatient unit was purpose built and had an open feel to it with communal space for patients and their families to use.

There were no visiting restrictions on the inpatient unit for friends or family of those receiving end of life care. Arrangements could be made for relatives who wished to stay the night with their loved ones. This enabled family and friends to spend unlimited time with their loved ones.

Meeting people's individual needs

Services were tailored to meet patients' individual needs and preferences. 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. However, the service did not maintain consistent records of patients' preferred place of care.

The service had a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met those needs. For example, there were three dementia champions within the service to support staff to ensure the needs of patients living with dementia were met. The service used blue flowers to discreetly identify those living with dementia, and staff completed a 'what matters to me' document to identify the individual needs of patients. The day service hosted a weekly synergy café and a monthly drop in service to support people living with dementia and their carers.

Care after death was managed sensitively and in a way which respected the wishes of families while following appropriate processes. This was evident from the conversations we had with staff and observations we

made during the inspection. Staff ensured families understood the practical arrangements needed after the death of their family member. Leaflets were available to provide guidance for families for what they needed to do following the death of a loved one.

The service took patients' spiritual, religious, psychological, emotional and social needs into account. This was evident from the patient records we reviewed and observations we made during the inspection. The service had a faith and end of life care document which contained information on numerous religions as guidance for staff. The document contained different practices and traditions in end of life care. For example, there was guidance on practices within Judaism whereby the body is not to be touched for 20 minutes after death and close relatives may make a tear in one of the patients' items of clothing. The service had a lot of religious resources available to patients, as well as non-religious items that were used for remembrance and reflection. The head of spiritual care ran regular meditation sessions.

Staff involved in care were informed of a person's advance care plan and preferred place of care. Patients were supported to develop an advance care plan, including a recommended summary plan for emergency care and treatment (ReSPECT), where appropriate. This was evident from the patient records we reviewed and our observations of the nursing and multidisciplinary handovers as well as ward round. We found that preferred place of care was discussed as part of advance care planning with patients on admission, although we found it was not discussed in one of the patient records we reviewed.

Staff made sure that patients, relatives and carers could get help from interpreters when needed. Staff told us that they were able to access interpreting services for patients when required, either via telephone or face to face.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients told us that they were offered sufficient food choices.

Staff understood the needs of people in vulnerable circumstances and planned care to meet their individual needs. Staff told us that the service had reached out to gypsy, roma and traveller communities to inform them



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of the services provided. The service held a training day for staff which included understanding the needs within these communities, and had started to develop links within these communities in the local area.

Staff monitored and reviewed the changing needs of patients through regular 'comfort rounds' and frequent medical reviews.

Information provided by the service following inspection stated that patients' preferred place of care (PPC) or preferred place of death (PPD) was not always recorded on their electronic system. The data for PPC and PPD was collected electronically, so it meant that the service did not have consistent information about PPC and PPD. Information provided by the service stated that the conversations about PPC and PPD often took place before the patient was admitted, or it was not appropriate to ask. The data held by the hospice which was shared with us following our inspection stated that the service held PPD conversations with 125 patients. Of those patients, nine were undecided and 116 expressed their PPD as either home, hospice or care home. Out of those 116 patients, 30 patients died in their own home, 67 at the hospice, 6 at the hospital and the remaining 13 were unknown. The service planned to raise this issue at the quality improvement group and clinical governance meeting to develop an action plan to ensure PPC and PPD data was collected consistently.

Access to the right care at the right time

People could access the service when they needed it. However, we could not be assured that waiting times from referral to achievement of preferred place of care and death were in line with good practice.

The hospice had effective processes in place to manage admission to the service. Referrals were made through a single point of referral process and were mostly made by GP's, nurses, community teams, the local hospital and the hospice at home team. Referrals were assessed twice a day at a referral meeting where patients were triaged and admitted according to their acuity and the capacity on the inpatient unit. Referrals data was collected and uploaded into the monthly integrated quality and performance report that was shared with all senior managers and team leaders.

The service was able to meet the needs of patients at the point they needed it. Any referrals that requested an

urgent or same day admission were reviewed by the inpatient unit manager and the lead doctor for the day as soon as the referral was received. A decision would be made regarding whether to admit the patient based on need and capacity.

During busy periods, if the service was unable to admit a patient immediately, it would endeavour to support the patient and their family at home through the hospice at home service. The hospice at home team provided nursing care, symptom control and psychological and emotional support for both the patient and their families, whilst working closely with other health care professionals.

The hospice at home did not provide a night service, however staff could arrange night visits for those who required them. That service was provided by other local hospice providers.

The service worked with local organisations to support patients to be discharged promptly to enable them to be cared for in their preferred place of care. Staff we spoke with told us there could be challenges to achieving discharge at times, but the hospice at home service was able to support these challenges by maintaining continuity of care in the patient's home environment, according to their wishes. Staff liaised with the district nursing service to ensure an appropriate care package was in place. Crisis visits could be arranged so that patients could be discharged promptly.

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.

The service had processes to ensure complaints were dealt with effectively, including prompt acknowledgement of the complaint, a written response to the complainant and whether changes had been made because of the complaint. The service offered face-to-face meetings with complainants. Staff understood the policy on complaints and knew how to manage them. They told us that where possible complaints were resolved immediately. Staff listened to the patient or relative to identify their needs and to address their concerns. If concerns could not be resolved



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informally, complainants were supported to make a formal complaint. Staff told us the service received very few formal complaints, which was confirmed by the number received within the inspection reporting period.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints and feedback was shared with staff through a variety of means such as newsletters, team meetings and noticeboards. Staff confirmed they received feedback on complaints. Action was taken in response to complaints and feedback received to improve patient experience and care provision. We saw 'you said, we did' boards displayed in the hospice with examples of improvements made in response to patient feedback. For example, one visitor commented that the car park was dark during the night. The service responded by installing six additional lights in the car park.

From August 2018 to July 2019, the hospice received one complaint. Managers investigated complaints thoroughly. Feedback from complaints was shared with staff, and learning was used to improve the service. The complaint was investigated and responded to in line with hospice policy, which stated complaints should be dealt with within 20 working days.

For the same reporting period, the hospice received 151 written compliments. The service had started to log compliments on their electronic reporting system to allow them to identify trends. Managers fed compliments back to individual staff members where appropriate.

Leaders demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. Leaders understood the issues, challenges and priorities in the service, and beyond, and proactively sought to address them. They worked collaboratively with partner organisations, stakeholders and other agencies to deliver high-quality, patient and family-centred palliative and end of life care services.

There was a clear management structure with defining lines of responsibility and accountability. The day to day management of the hospice was undertaken by the senior leadership team. This included the hospice director, head of clinical services, head of support services and head of hospice fundraising. They were supported by the medical team, managers and leads of each department. The senior leadership team was accountable to the Sue Ryder executive leadership team, who in turn were responsible to the council of trustees. The hospice director reported directly to the director of nursing and hospices.

We spoke with one of the Sue Ryder trustees, who told us they were kept well informed of what was happening within the hospice. They spoke about the well-established leadership team and the positive patient feedback received by the hospice. Members of the council of trustees chaired various governance sub-committees and met bi-monthly as a board. This ensured they met their governance responsibilities and maintained oversight of the quality and safety of care. There were 13 trustees on the council from a variety of backgrounds, all of who had or still held senior executive positions, including within the NHS. Two of the trustees were practising consultants; one in palliative medicine and one in neurology.

Staff we spoke with were generally positive about their leaders and described them as supportive. They told us they were very visible, approachable and that they felt well supported. We observed this during the inspection.

Staff felt connected to other teams within the service and the organisation as a whole. Staff from the inpatient unit told us they worked well with the hospice at home service to support the needs of patients.

The service provided development opportunities for staff that supported them to develop leadership skills. For example, staff had the opportunity to attend additional

Are hospice services for adults well-led?

Outstanding



Our rating of well-led improved. We rated it as **outstanding**.

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.



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training to increase their competencies and support them to undertake more senior roles within the service. Staff we spoke with told us that there were lots of training opportunities available.

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 strategy was fully aligned with plans in the wider health economy and there was a demonstrated commitment to system-wide collaboration and leadership.

There was a clear vision, mission and set of values, with quality and sustainability as the top priorities. The hospice vision, mission and values were those of Sue Ryder, and were focused on providing high-quality palliative care for patients and those close to them living with life-limiting conditions. The Sue Ryder vision was, “We see a future where our palliative and neurological care reaches more communities; where we can help more people begin to cope with bereavement; and where everyone can access the quality of care they deserve.” The mission was, “Sue Ryder supports people through the most difficult times of their lives. Whether that’s a terminal illness, the loss of a loved one or a neurological condition – we’re there when it matters. Our doctors, nurses and carers give people the compassion and expert care they need to help them live the best life they possibly can.”

The service had an established set of values, which were:

- Make the future together – sharing our knowledge with each other and collaborating with our volunteers, supporters and people who use our services to deliver positive outcomes.
- Do the right thing – working with honesty and integrity, having courage and resilience to face the challenges in delivering our goals.
- Push the boundaries – constantly looking at ways to improve what we do and how we do it, with creativity and innovation.

The values were underpinned by Sue Ryder ‘behaviours’ which staff were expected to demonstrate at all times. These included emotional awareness, honesty and

integrity, resilience, delivering outcomes and working together. The appraisal process incorporated these values and behaviours, whereby staff had to evidence how they demonstrated them at work. We saw the Sue Ryder vision, mission and values were publicly displayed throughout the hospice. Most staff we spoke with could describe the Sue Ryder vision and mission.

Sue Ryder had developed a five-year strategy for 2018 to 2023. This had been developed in collaboration with staff, service users and external partners, and was aligned to national recommendations for palliative and end of life care. The strategy recognised the challenges presented by a growing and ageing population, with more people being diagnosed with complex conditions, and outlined how the organisation planned to deliver services which met the needs of more people and enabled them to access personalised, life-enhancing care. There were two strategic aims: provide care and support for more people and influence new models of care across the UK. In partnership with relevant stakeholders, the hospice had worked to develop services in line with the strategy, such as the work on transitions for young people moving from children’s to adult hospices. Progress against delivering the strategy and local plans were monitored and reviewed.

Culture

Staff were motivated to provide the best care they could for their patients. There was a common focus on improving the quality and sustainability of care and people’s experiences. Staff felt respected, supported and valued. The service had an open culture where patients, their families and staff could raise concerns without fear.

We observed that staff were passionate about the care they provided and were proud to work at the hospice. Staff told us they loved their jobs and were committed to providing the best possible care for patients and those close to them. They felt it was a “privilege” to care for people at the end of their life. Throughout our inspection, we observed positive and respectful interactions between staff at all levels. Staff told us they all worked well together, they supported and cared for each other and treated each other with respect. Every staff member we spoke with remarked on the real sense of team working throughout the hospice.



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Staff told us they felt supported, respected and valued. They described the culture within the service as open and positive. Leaders were visible, accessible and supportive. The senior management team promoted an 'open door' culture and wanted staff to find them approachable. Staff told us they felt confident to voice any concerns or issues they had. Arrangements were in place to ensure staff could raise concerns safely and without fear of reprisal, including a whistleblowing policy which staff could access from the hospice intranet.

The culture of the service was centred on the needs of patients and those close to them. Staff described many examples of ways they met the individual needs and wishes of patients, and to helped them to live each day to the fullest. Many of the volunteers who worked at the hospice were relatives of patients who had been cared for by the service. This demonstrated how positively former service users felt about the hospice and the care they provided.

Leaders spoke with pride about the work and care their staff delivered daily. They celebrated staff success by sharing positive feedback received and positive contributions made by staff. Staff were invited to nominate colleagues in recognition of going above and beyond their role. The hospice director sent thank you 'spotlight cards' to nominated staff. Sue Ryder held an annual awards event which recognised the contributions of staff and volunteers. These events were attended by trustees.

There was a strong emphasis on the safety and wellbeing of staff. Measures were in place to protect the safety of staff who worked alone and within teams in the local community. Hospice at home staff had an agreed phrase that they used when contacting colleagues which meant they were in danger, without alerting anyone they were with that they were requesting assistance. The service had CCTV equipment so staff working on the inpatient unit at night could see who was entering the hospice.

The culture encouraged openness and honesty. The service had processes to ensure the duty of candour was met, including training for staff. Staff understood the duty of candour and confirmed they were encouraged to be open and honest with patients, families and carers.

There were mechanisms for providing staff at every level with the development they needed, such as appraisals

and one-to-one discussions. Staff spoke positively about development and training opportunities. Action was taken to address behaviour and performance that was inconsistent with the vision and values, regardless of seniority. We were given examples of when this had occurred.

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.

There were effective governance structures, processes and systems of accountability to support the delivery of good quality services and safeguard high standards of care. Monthly quality improvement group meetings were held. These followed a standing agenda which was aligned to the Care Quality Commission (CQC) domains of safe, effective, caring, responsive and well-led. We reviewed meeting minutes from May, June and July 2019 which confirmed governance matters, such as incidents, risks, complaints, feedback, audits, and training compliance, were discussed. The integrated quality and performance report was also reviewed in this meeting as it provided up to date information and data on all services and performance areas related to quality and risk.

Quality and risk information about the service was reviewed at hospice through to board level, such as staffing metrics, incidents, complaints and activity. The governance and risk structure for Sue Ryder showed information discussed at quality improvement group meetings fed into relevant corporate groups, such as the medical devices group and the learning development workforce group. These groups fed into the health governance committee, which fed into the health and social care sub-committee, which fed into the council of trustees (board) meetings. This meant there was oversight of the service from hospice to board level.

Staff at all levels were clear about their roles and had a clear understanding of their accountabilities and who



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they reported to. Staff were committed to improving the quality of service provision and maintaining high standards of care. Staff knew how to report incidents and told us they were encouraged to do so.

Arrangements were in place to manage and monitor contracts and service level agreements with partners and third-party providers. Contracts were reviewed on an annual basis, which included a review of quality indicators and feedback, where appropriate.

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.

There were clear and effective processes for identifying, recording, managing and mitigating risks. The hospice had a local risk register which included a description of each risk, the potential impact of the risk and the risk owner, alongside mitigating actions and controls in place to minimise the risk. Each risk was scored according to the likelihood of the risk occurring and its potential impact. At the time of our inspection, four risks were detailed on the risk register; one of which related to patient records being documented both electronically and on paper records, leading to a risk of missed information and duplication. The risk register had been recently reviewed and action had been taken to minimise each risk. Risks were reviewed regularly at weekly senior management team and monthly governance meetings. There was alignment between the recorded risks and what staff identified as risks within the service.

Individual risk assessments were carried out for each patient on admission to the service. These were reviewed regularly. When a risk was identified, we saw actions were taken to minimise any potential harm to the patient, such as from falls or pressure ulcers.

External companies were employed to undertake specialist risk assessments where appropriate. For example, an environmental health assessment was carried out in June 2019 which showed no areas for concern. One recommendation was made in relation to documentation but there were no issues raised relating to safety.

Incidents reported were reviewed regularly by senior staff and where necessary, investigations were initiated to identify any themes and actions needed to minimise recurrence. We saw there were 30 incidents under review as of December 2019. The corporate quality team and chief executive for Sue Ryder had oversight of all incidents reported.

There was a programme of clinical and internal audit. This was used to monitor quality and operational processes, and results were used to identify where improvement action should be taken. Staff confirmed they received feedback from audits.

The service had an up to date business continuity management plan which was accessible to staff and detailed what action should be taken and by who, in the event of a critical incident involving loss of building, information technology or staff. Emergency contact numbers for managers and services was included.

Staff confirmed they received feedback on risks, incidents, issues and performance in a variety of ways, such as team meetings, noticeboards, newsletters and email.

Managing information

The service invested in best practice information systems. Staff could mostly 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.

There was a holistic understanding of performance which sufficiently covered and integrated people's views with information on quality, operations and finances. Clear and robust service performance measures were reported and monitored. Staff had access to quality and performance data through the monthly integrated quality and performance report. We saw these reports were detailed and included data on a range of performance and quality indicators, such as incidents, staffing, service user feedback, complaints and activity. Areas of good and poor performance were highlighted and used to challenge and drive forward improvements. Statistical process control (SPC) charts were used to track performance over a period of time, where relevant, and to



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highlight unexpected variations in performance which warranted investigation. This meant staff could identify at a glance, performance trends and areas that required investigation and improvement.

There were effective arrangements to ensure data and statutory notifications were submitted to external bodies as required, such as local commissioners and the Care Quality Commission (CQC). There was transparency and openness with all stakeholders about performance. For example, the service shared a quality dashboard with the local clinical commissioning group. The information reported included a range of performance and quality indicators.

Staff mostly had access to up-to-date and comprehensive information regarding patients' care and treatment. The electronic patient record system was the same as that used by local GPs, district nurses and Macmillan nurses. There were arrangements to ensure confidentiality of patient information held electronically and staff were aware of how to use and store confidential information. Computers and laptops were encrypted, and password protected to prevent unauthorised persons from accessing confidential patient information. The service encouraged use of passwords for family and carers for sharing information over the telephone to protect patients' confidentiality. However, information about preferred place of care (PPC) held and collated electronically was not always recorded on the electronic system. As the data for PPC was collected electronically, it meant that the service did not have consistent and accurate information about PPC. The service planned to develop an action plan to ensure PPC data was collected consistently.

Engagement

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

People's views and experiences were gathered and acted on to shape and improve the service and culture. Patients, families and carers were encouraged to share their views to help improve services. Feedback was reviewed by staff and used to inform improvements and

learning, where possible. Volunteers gathered real-time feedback, which was shared with staff and fed back at governance meetings. The aim of real time feedback was to ensure issues would be acted upon quickly.

The hospice at home service undertook a patient and family survey for 2018-2019. The results of the survey were overwhelmingly positive. The survey asked questions that included whether staff explained the care that would be provided, whether patients and carers felt supported, whether care was tailored to meet patients' needs and whether they felt able to express any worries or fears. Comments made in the survey included: "[Hospice at home] kept my [spouse] from admission onto a hospital ward via A and E until a bed in the hospice became available". Another stated "It gave me peace that someone professional was caring for my [parent] and made them as comfortable as is humanly possible".

There were high levels of engagement with patients, families and carers, partner organisations and the public. For example, families and carers were invited to attend the hospice for an annual day of remembrance, known as the 'Lights of Love' event, where people could come together to reflect and remember their loved ones. The service ran a palliative link day. It was an event that GPs and district nurses were invited to where hospice staff delivered training on advanced care planning, and also to raise the profile of the hospice.

Since our last inspection, the hospice had established a service user group, known as Impact. The Impact group met on a monthly basis. The head of support services was present at these meetings, but the meetings were chaired by a volunteer. All members of the group had family members who were cared for by the hospice. The Impact group sought real time feedback from patients and carers which was fed back to managers and all hospice staff. A member of the Impact group attended the quality improvement group which ensured the senior leadership team was aware of any concerns which could be monitored and acted upon.

The views of staff were sought and acted on. Staff were invited to participate in the annual Sue Ryder staff survey. In the February 2019 survey, the hospice scored 7.2 (out of 10) for an overall indicator of staff engagement. This was slightly lower than the national Sue Ryder average of 7.5, and indicated staff were reasonably well engaged. The service scored highly for areas such as; staff would be



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happy for their family to be cared for in one of the Sue Ryder centres, staff were clear on the values and vision of Sue Ryder, and staff felt motivated to help provide more care to more people. Lower scoring areas in the survey were staff feeling they were rewarded fairly in their job, feeling that the organisation valued its staff, and feeling individual and team achievements were recognised.

From the conversations we had with staff and observations we made during the inspection, it was evident that staff were engaged in the service. They told us they felt confident to raise concerns and were encouraged to come up with ways in which services could be improved. Information was shared with staff in a variety of ways, such as handovers, email, noticeboards and staff events.

Learning, continuous improvement and innovation

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.

The occupational therapist and physiotherapist on the inpatient unit introduced a wellbeing café on the unit for patients, relatives and staff to attend. It was developed from feedback from patients who stated they sometimes felt bored and would like somewhere to go. The wellbeing café provided some structure, yet was also

social and informal. Sessions included wellbeing, relaxation and symptom management. The sessions provided at the café were patient led depending on those who attended the groups. This type of group was not commonly used in inpatient services and the therapists presented their initiative at a Hospice UK conference in November 2019 to many other professionals.

The practice educator led on improvement in education and training at the hospice. The practice educator worked closely with other local healthcare educators, palliative care clinical nurse specialists and facilitated study days for link nurses from the local hospital and community teams. All clinical staff completed a training needs analysis, and training was subsequently organised based on the analysis results. For example, specific registered nurse study days were held which covered ReSPECT, medicines management, opioid workbooks and single nurse administered controlled drug assessments. The hospice took on student paramedics and educated them to help patients avoid admissions to acute hospitals when they required end of life care.

One of the volunteers on the inpatient unit had been awarded 'young volunteer of the year' at a volunteering award ceremony in the local area. The annual event was held to recognise the many volunteers and voluntary organisations across the local area for the work they did to help people in their community.

Outstanding practice and areas for improvement

Outstanding practice

- The service collaborated with external palliative care staff to make improvements in nutrition for patients. The service introduced smaller plate sizes to make meals feel more manageable to patients. The service also introduced moulds so that pureed food was presented in the shape of the item to make it more appealing. For example, pureed carrots were presented in the shape of a carrot for those patients who required that type of specialised diet.
- The service ran an annual day of remembrance, known as the 'Lights of Love' event. Families and carers were invited to attend the event to reflect and remember their loved ones.
- The occupational therapist and physiotherapist developed and ran a wellbeing café on the unit for patients, relatives and staff to attend. The wellbeing café provided some structure, yet was also social and informal. Sessions included wellbeing, relaxation and symptom management.
- The service worked with another local hospice and a local children's hospice to help develop a transition pathway of care for children transferring from children's to adult services. The service planned to employ a full time transition lead to work across all hospices involved in a regional action group for transitions. The service facilitated three transition events over the last year, which included arranging events for young people and their relatives to attend.

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should maintain consistent records of patients' preferred place of care and preferred place of death to provide full oversight of service performance.