Hospice in the Weald

The Cottage Hospice

Inspection report

Five Ashes
Mayfield
TN20 6HY
Tel: 01892820500
www.hospiceintheweald.org.uk/contact

Date of inspection visit: 2 August 2021
Date of publication: 27/09/2021

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, 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 to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Overall summary

We rated this location as outstanding because:

- 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.
- 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.
- People were truly respected and valued as individuals and were empowered as partners in their care. Staff fully involved people and treated them with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service tailored planned care to meet the needs of individual people, took account of patients' individual needs, and made it easy for people to give feedback. People received care in a way that was flexible, offered choice and continuity. People could access the service when they needed it and did not have to wait too long for treatment.
- The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. 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.

Summary of findings

Our judgements about each of the main services

Service	Rating		Summary of each main service
Hospice services for adults	Outstanding	☆	We rated this service as outstanding because: See overall summary for details.

Summary of findings

Contents

Summary of this inspection

Our findings from this inspection

Summary of this inspection

Background to The Cottage Hospice

The Cottage Hospice is operated by Hospice in the Weald. It is a local charity providing an emergency support care service for individuals diagnosed with a terminal illness who are at the end of their life and require non-complex care needs. The service serves the communities of West Kent and East Sussex. This location offers people and those important to them an alternative option when deciding their preferred place of care and death. Unlike traditional hospice models, the model at The Cottage Hospice is unique; the family caregiver stays in the hospice with the patient throughout a patient's stay. The family caregiver has the freedom of leaving the hospice to attend to their personal needs with peace of mind that hospice staff are available to care for their loved one. The service uses the term "family caregiver" to describe the people who will be caring for their loved ones in The Cottage Hospice. Trained staff that includes nurses, nursing assistants and volunteers provide support to the patient and the family caregiver.

The service focuses on the family caregiver providing end of life care to their loved one. The hospice provides emergency carer support in one type of setting: a 10-bedded "home from home stay" unit. The service is available 24 hours a day, seven days a week. Staff and the family caregiver provide care and support to patients with non-complex symptoms at the end of life.

All 10 suites are spacious and fully equipped; each with an electronic bed and pressure relieving mattress, a walk-in bathroom, storage, a tea/coffee making facility, a fridge and a table with seating for two. Each suite also has a smart television and an electronic tablet with free WiFi connectivity. All suites have access to a private covered balcony through a ceiling-to-floor sliding glass door, with a table and seating for two. The environment enables patients to keep their family close to them and as comfortable as possible. Family members and those important to the patient are encouraged and supported to provide the care.

In each suite, there is a second bed or a sofa bed, and there are also two guest rooms available for additional visitors.

The location is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. They have legal responsibility for meeting the requirements set out in the Health and Social Care Act 2008. The hospice had made a valid registered manager application to CQC, and the applicant is awaiting formal interview and registration. The applicant also held the role of the hospice care director.

This location registered with the Care Quality Commission in December 2019 and this is its first inspection.

How we carried out this inspection

Our inspection team

The team that inspected the hospice comprised a CQC lead inspector and a specialist advisor with expertise in end of life care. The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.

During the inspection visit, the inspection team:

- visited the rooms/suites at the hospital, looked at the quality of the rooms/suites and surrounding environment and saw how staff were caring for patients.
- spoke with the care director and head of service.
- spoke with six other members of staff including one doctor, one nurse, two nursing assistants, one manager and one housekeeping staff.
- spoke with three patients and one relative who were using the service.
- reviewed three medicines prescribing and administration records.
- looked at a range of policies, procedures and other documents relating to the running of the service.

After the inspection visit, the inspection team:

- virtually reviewed three patient care and treatment records
- reviewed service information such as performance, training compliance, audits, policies, feedback from patients and family caregivers, and staff.

Activity

In the reporting period 1 June 2020 to 30 June 2021, the hospice had 3,500 bed days (10 beds) with a 50% occupancy rate.

The accountable officer for controlled drugs (CDs) was the head of service at the provider's other location Hospice in the Weald, who was a non-medical prescriber.

Track record on safety:

- Zero never events
- Zero serious injury
- Zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA)
- Zero incidences of hospital acquired Clostridioides difficile (C.difficile)
- Zero incidences of hospital acquired E-Coli
- Two complaints that were not related to care

Services provided at the hospice under service level agreement included:

- Waste management
- Pharmacy services

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

- We found a culture that actively encouraged staff at all levels to raise concerns and suggest improvements. We found examples of a nursing assistant who raised concerns and made suggestions about how the service used the term “carer breakdown support”, to promote the services this location offered. The leadership team took on board their concerns and raised this to the board. Leaders adopted the recommendations made by the member of staff and renamed it to “emergency carer support”.

Summary of this inspection

- The hospice had developed an “Informed Guide” to empower family caregivers looking after their loved ones in their final days of life. The purpose of the guide was to lessen any feelings of anxiety and supported family caregivers with practical tips. They were available through a variety of formats such as easy to read print, short videos and the hospice website.
- The provider was an accredited National Vocational Qualification (NVQ) centre. It offered free dementia and end of life care courses for staff in local residential homes and domiciliary care agencies to study and gain qualifications. The centre also offered apprenticeships in health and social care.
- The service had agreed to implement shared electronic records in collaboration with local hospitals, GPs, mental health services and the community, for sharing real-time information which supported effective decision-making to provide coordinated care at the right time and place for patients and family caregivers.

Our findings

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

Outstanding ☆

Hospice services for adults

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

Are Hospice services for adults safe?

Good ●

We rated safe as good.

Mandatory training

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

All staff received and kept up to date with their mandatory training. The completion rate for mandatory training for all staff was 100%.

The mandatory training was comprehensive and met the needs of patients, staff and volunteers. Staff we spoke with said they felt confident carrying out their role and applied training to their practice. They found managers fully supported them if they required additional training.

Clinical staff also completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Leaders supported staff to complete and attend mandatory training sessions. All sessions were provided either in person or virtually, and during the pandemic only virtual sessions were held. The service had now re-introduced face-to-face sessions since the pandemic restrictions had eased.

Managers monitored mandatory training and alerted staff when they needed to update their training.

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 hospice's safeguarding policies for adult, children and young people at risk were in date. They were detailed, clear and included key contact names and details and included the hospice's named safeguarding lead. Staff knew where to access the policies and had easy access to them.

Staff and volunteers received safeguarding training specific for their role on how to recognise and report abuse. Data showed 100% of required staff had received training in adult safeguarding level 2. Of the required staff, 100% had received training in children and young people safeguarding level 1. The care director who is the safeguarding lead was trained in adult safeguarding level 3. This showed the service complied with the Adult Safeguarding Intercollegiate Document, August 2018 and the Children and Young People Intercollegiate Document, January 2019.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw two safeguarding referrals to the relevant authorities and the service completed a thorough investigation. Learning was shared across the hospice through one-to-one and team meetings.

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

The service had processes to undertake Disclosure and Barring Service (DBS) checks when staff began working for the organisation. This included paid staff and volunteers.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients in individual room suites. Staff used control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The hospice areas, including patient room suites, were clean and had suitable furnishings which were clean and well-maintained. All relevant areas had hand washing facilities and there was access to wall mounted hand sanitiser dispensers operated by sensors throughout the hospice. Disposable sanitising wipes were available to ensure surfaces could be cleaned.

The hospice performed well for cleanliness. The hospice produced a yearly infection prevention report, in addition to the more frequent infection prevention and control audits such as hand hygiene, personal protective equipment and environment. The yearly infection prevention report brought together all the smaller audits and looked for themes and areas that required improvements over the coming year. The hospice infection prevention and control lead carried out the audit in April 2021 and found the hospice to be 97% overall compliant. This was scored using Hospice UK's audit for monitoring infection control standards which aligned with the Department of Health standards.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

The hospice had standard operating procedures for cleanliness, infection control and hygiene and COVID-19 specific processes that aligned with national guidance. Staff followed infection control principles including the use of personal protective equipment (PPE). They adhered to best hand hygiene practices; we saw staff used hand sanitiser and washed their hands at appropriate times. The entire unit had sensor automated handwash soap and gel dispensers to avoid surface contact which minimised a risk of cross infection. All staff adhered to the 'bare below the elbows' best practice when delivering care. All staff, patients and visitors were required to have their temperatures taken before entering the premises.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

The service had a clear procedure for looking after a patient after death and staff followed this. Staff made sure they guided family caregivers who chose to participate in the process of washing their deceased relative about the procedure should they wish. There were effective arrangements with undertakers and the service reported no issues with any delay in transfers from this location. This helped the service protect the health and safety of everyone who comes into contact with a patient's body after death.

Staff worked effectively to prevent infections. The hospice had no incidents of Clostridioides difficile (C.difficile), MRSA, vomiting or diarrhoea outbreaks in the past 12 months.

The hospice completed regular water testing for legionella and bacteriological infections and prioritised high-risk areas to have more regular checks. This included notifying the relevant external agencies if required. The most recent testing in January 2021 recommended actions to address some risks, and the service planned to carry out works and maintenance where indicated.

Environment and equipment

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

The environment of the hospice was well designed. The facilities, premises and equipment were well maintained. It was evident that patients and family caregivers were at the heart of the design.

Staff carried out daily equipment safety checks so they were safe to use when required.

We saw all patients could reach call bells and staff responded quickly when called.

The service had exceptional facilities to meet the needs of patients and family caregivers. Facilities included a fully equipped kitchen if a patient or family caregiver wished to use it. People had access to a café which was fully stocked with drinks, fruit, biscuits and tea/coffee making facilities. Free Wifi was available throughout the premise and there were two guest rooms with an en-suite toilet and shower. There were adequate and free parking facilities, including two electric car charging bays.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely. We saw waste bags were not overfilled. Staff explained they disposed of a clinical waste bag when it reached two thirds full. This complied with the hospice procedure for waste management.

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 used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Patients and family caregivers said staff knew the support and care to give including when the care needs changed.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. For example, patients told us one of the areas staff checked is the type of pressure area care they needed. Staff made sure a patient had the correct level of pressure relief set on a mattress and that the patient felt comfortable.

Staff had knowledge of specific risk issues and knew how to deal with them. They always reported sepsis, venous thromboembolism, falls and pressure ulcers when required.

The service had 24-hour access to mental health support, if staff were concerned about a patient's mental health.

Staff completed psychosocial assessments and risk assessments for patients including patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. We saw thorough discharge plans when patients were discharged from the service. These were shared, with the patient's permission, with others such as the patient's GP or district nurse. This connected care and kept any gaps in provision of care to a minimum. The hospice had plans to implement shared electronic patient records with GPs and other health and social providers, to provide a coordinated care approach.

Staffing

The service had enough medical, nursing, support staff and volunteers 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. Managers gave bank staff and volunteers a full induction.

The service had enough medical, nursing, support staff and volunteers to keep patients safe.

Managers accurately calculated and reviewed the number and grade of medical staff, nurses, nursing assistants and volunteers needed for each shift in accordance with national guidance.

Managers could adjust staffing levels daily according to the needs of patients.

The number of nurses and nursing assistants matched the planned numbers.

In the reporting period from 1 June 2020 to 30 June 2021, the service's turnover rate was 52% (9.1 out of 17.4 whole time equivalent staff). The service confirmed this was highly unusual and attributed this to the impact of the pandemic when the service was stopped and restarted, and some staff wanted to work in a more traditional hospice model. By August 2021, the hospice was almost fully staffed with plans to recruit two further nursing posts at the time of inspection.

In the same reporting period, the service had a sickness rate of 10.5%. Leaders told us this was mainly due to staff that had continued to work on the frontline throughout the pandemic. We were informed the sickness rate had been reducing since a peak in January 2021.

The service had low bank and locum staff usage rates. Managers limited their use of bank and locum staff and only requested staff familiar with the service. They made sure all bank staff had a full induction and understood the service. Bank staff told us they completed mandatory training and were provided ongoing training required for their role.

Staff had access to a consultant on call during evenings and weekends if required.

Records

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

All patient records, except for drug charts, were electronic. Staff showed us they could access them easily.

We reviewed three patient records and found they were clear, up-to-date and comprehensive.

There were no delays in staff accessing patient records.

Records were stored securely. Staff had an individual log-in and they had the correct access level specific to their role.

Medicines

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

The service had systems and policies to make sure people were safe; for patients who were self-administering their oral medicines and family caregivers who were supporting their administration. The service carried out risk assessments to assess whether a person was suitable to self-administer their oral medicines. A qualified nurse administered oral medicines if required.

Controlled drugs were dispensed from obtaining them on an individual prescription. This was in line with the Misuse of Drugs Regulations 2001.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patients and family caregivers we spoke with knew the medicine they were taking and the reasons for taking it. They said staff gave them clear information about the medicine and they received patient information leaflets about their medicines.

Medicines were stored safely and securely, in locked medicine cupboards within secure lockers in people's rooms. Medicines that require additional controls (controlled drugs) because of their potential for abuse were stored securely.

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

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

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

Policies and guidelines had up to date references which provided information about the safe and correct use of medicines. The service held regular medicines management meetings and medicine incidents were reported and reviewed. The service had taken actions following previous medicine errors to minimise the recurrence of such errors. Staff administering medicines received a refresher course when there was an identified need.

To complement medicine audits, two trustees with clinical experience and relevant qualifications undertook random checks on the progress of any identified action plans. The external pharmacist also carried out weekly spot checks. This made sure new implementations and processes were embedded in practice, and people could be confident that all aspects of their medicines were monitored effectively to keep them safe.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The head of service had oversight of making sure staff adhered to safety alerts and incidents. An example was the service acted from a recent safety alert related to a syringe driver that required an additional battery to operate. Staff understood the safety alert and explained what they needed to do with the additional battery when in and out of use.

We reviewed five medicine administration records and found one out of the five had an inaccurate balance written for one medicine. We raised this with the head of service who took immediate action to address our concern. We saw two staff counted the medicine and confirmed the error was only in writing as the number that remained in the packet was correct when matched against the prescription. They made sure the correct balance was written in the medicine administration record, signed and dated the error. Staff told us they checked all medicine administration records daily and were due to check at the next handover. We also saw staff reported this incident which aligned with the hospice policy. We were told actions would include reminding staff to check at every handover shift, carrying out a snapshot audit and increasing the frequency of regular audits to every three months. This made sure people were administered their medicines as prescribed and at the correct times to keep them safe.

Incidents

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

Staff knew what incidents to report and how to report them. Staff reported incidents using the hospice's electronic reporting system. Staff showed us they had easy access to the system.

The service incident policy was in date. This clearly outlined the roles and responsibilities of staff, including duty of candour when applicable. Staff raised concerns and reported incidents and near misses in line with the service policy.

The service had reported no serious incidents or never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.

Staff understood the duty of candour. They described how they would be open and transparent. Staff would give patients and families a full explanation if things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident or if staff had to deal with a difficult situation.

Are Hospice services for adults effective?

Good ●

We rated effective it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance.

The service had care plans to support staff delivering care to patients in the last days and hours of life. The care plans demonstrated best practice in relation to planning end of life care, including a holistic approach to the needs of patients and their loved ones. This was in line with the 'Every Moment Matters' narrative from The National Council for Palliative Care, March 2015.

We saw anticipatory medicines prescribed for pain management, breathlessness, nausea, distress and agitation. These were given in line with the National Institute of Health and Care Excellence (NICE) guidelines for care of the dying adult in the last days of life and palliative care for adults. The hospice audited the use of these anticipatory medicines to ensure patients were benefitting from them.

The hospice used a carer support needs assessment tool to ensure family caregivers needs were also considered and met. Following a bereavement, the hospice ran a bereavement support group “T-junction” and invited family caregivers to provide support through the bereavement process.

The hospice used recognised quantity measures to identify whether patient goals and outcomes were being met and potentially improving. The hospice used Integrated Palliative Outcome Score (IPOS) which was a tool to identify patient priorities of care and changes in patient symptoms. The IPOS was designed to create a standardised set of outcome measures for use in palliative care and was focussed on promoting a holistic and patient-centred approach.

The hospice used the Karnofsky Performance Status Scale (KPS) to standardise its measure of a patient’s status. KPS is a standardised tool used to measure the ability of a patient to perform daily tasks. A higher score means that a patient is better able to carry out daily activities. All staff were knowledgeable about the different points on the scale.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. All staff we spoke with had a good understanding of the Mental Health Act and could explain how they would ensure a patient’s rights were protected.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We saw staff thoroughly discussed patients, relatives and carers holistic needs. Staff discussed potential social worker involvement and began planning for post bereavement care. Staff also placed an emphasis on the spiritual wellbeing of patients and the hospice arranged for religious leaders to attend the hospice according to a patient’s wish.

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 made sure patients and family caregivers had support with nutrition and hydration to meet their needs. Patients and family caregivers had access to a choice of food, snacks and drink throughout the day and night.

Mealtimes were flexible to suit a patient and their family caregiver. This service offered a choice of nutritiously prepared meals and the facility to heat up the food. Family caregivers could also bring in food of their choice. There was a fully equipped kitchen with cooking facilities; patients and family caregivers could make themselves food and drink, and staff supported them if required.

Staff monitored a patient’s fluid and nutrition throughout the day to keep a patient as comfortable as possible. Staff recorded their observations in patient records.

Staff could refer patients to the community dieticians or speech and language therapists for specialist input to help with a patient's care if needed. Staff knew how to access these services and we saw staff recorded referrals in patient records when required. Staff explained how they communicated any advice to the family caregiver, to ensure patients were not put at unnecessary risk of choking.

The hospice had developed an "Informed Guide". This was organised as a series of practical tips to help a family caregiver support their loved ones. Topics ranged from eating and drinking when nearing death, mouth care to toileting needs. The guide also included a video clip for each of the topics, top tips, an important note and information on resources to support patients and family caregivers. People could access the guide in various formats; in print and on the smart TV in each patient suite, and the hospice website.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They worked closely with the patient and family caregiver to understand and support those unable to communicate and gave additional pain relief to ease pain.

Staff assessed patients' pain and gave pain relief in line with individual needs and best practice. There was an individualised and patient driven approach to pain relief. Staff routinely assessed patients' pain level during routine observations, and as required. We spoke with three patients and none reported being in pain. All patients told us staff had managed their pain and comfort as best as possible

The serviced used Palliative Care Formulary 6 and "Managing symptoms for an adult in the last days of life" NICE pathway, November 2020 for pain and symptom control. These guidelines are evidence-based approaches to managing pain and symptoms in patients at the end of life.

Medical staff prescribed anticipatory medicines for pain relief in patients approaching the end of life. Anticipatory medicines are prescribed before a patient requires them to ensure they are available once a patient does require them.

Staff had access to syringe drivers to administer pain relief. Staff did not raise any concerns about accessing equipment, such as syringe drivers, to support patients in pain.

Not all patients at the end of life experience pain. Some patients preferred to live with some pain to allow them to feel less drowsy and enable communication with family and loved ones. The hospice worked with these patients to balance pain relief with side or symptom effects.

Staff prescribed, administered and recorded pain relief accurately. We reviewed medicine charts and found them to be completed in full and demonstrated that patients received the correct medicine at the right time, unless the patient had refused it.

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 an effective approach to monitoring and recording patient outcomes, using a variety of audit techniques. The service used patient and family caregiver feedback to establish when they had provided care that met people's needs. To support this feedback, the service used patient reported outcome measures (PROMS) and family reported outcome measures (FROMS). Relevant governance committees reviewed the information and reported to the board through committee papers. Managers and staff used the information to improve patients' experience of care and treatment. Patients and family caregivers told us they benefitted from the improvements.

The hospice recognised this "home from home" care model (the family caregiver stayed in the hospice with the patient) was new and unique, therefore there were no national audits to benchmark its service. However, the service carried out audits and collected relevant information to benchmark itself. One type of information the service collected is about a patient's preferred place of care and death. The service reviewed the quality and outcome of this information to make sure they met people's needs.

The hospice participated in Hospice UK benchmarking for falls, pressure ulcers and medicine incidents. Information showed the service monitored the themes and trends and took relevant actions to address any identified issues.

Staff used nationally recognised tools to plan the transition of place of care. Staff holistically assessed a patient's and family caregiver's needs in accordance with best practice guidance. This included the use of recognised best practice assessment tools to measure people's palliative and end of life healthcare needs. Staff reviewed and monitored the scores from these assessments, recorded them in patient care records and shared them at handover meetings.

The service had an annual comprehensive audit programme. Managers and staff carried out a programme of repeated audits to check and monitor improvement over time. Managers shared feedback through emails, team meetings and at shift handovers to make sure staff understood information from the audits.

The hospice used the integrated palliative care outcome score (IPOS) to assess their effectiveness for individual patients. These scores were also looked at on a hospice wide level to ensure patients benefitted from inpatient care. These were scrutinised at the quarterly quality and governance meetings and were used as indicators to ensure the changes to the model of care was not negatively impacting on the quality of care and the outcomes for patients.

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.

Managers gave all new staff a full induction tailored to their role before they started work. The service provided staff with relevant training, supervision and support as needed.

Staff told us managers supported them to develop through yearly, constructive appraisals of their work. Staff had opportunities to develop and gain promotion within the hospice. Information showed 100% staff had completed their appraisals.

Managers supported nursing and medical staff to develop through regular, constructive clinical supervision of their work. The clinical educators supported the learning and development needs of staff.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers also identified any specialist training for the role of a staff and gave them the time and opportunity to develop their skills and knowledge. This was evident in all the staff records we reviewed.

Staff records had discussions of staff performance and staff told us managers promptly supported staff to improve when required.

Volunteers formed a key part of the staffing arrangements. Managers recruited, trained and supported volunteers to support patients in the service. Volunteers received a full induction when they started work.

Multidisciplinary working

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

The hospice had a cohesive approach to multidisciplinary working to ensure a holistic approach to the care delivery.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The service undertook daily multidisciplinary team (MDT) meetings which included doctors, nurses and therapy staff. MDT meetings were well structured and were coordinated to ensure that all professionals had equal opportunity to express their view. All MDT decisions were clearly documented in patient records, ensuring all staff involved in the care of the patient understood the goals, plan and desired outcomes

We found a multidisciplinary approach to all aspects of care delivery. For example, pharmacy staff spent time with junior doctors to provide an overview of medicine prescribing and ensure that patients received the correct medicine as need.

Staff worked across health care disciplines and with other agencies when required to care for patients. We found nursing and support staff, including volunteers and chaplaincy staff, worked well together to meet the holistic needs of patients. This allowed patients to meet their own personal goals, particularly in the last weeks and days of life.

Staff assessed mental health needs as part of a patient’s holistic needs assessment and told us they could refer a patient and a family caregiver for specialist advice if required.

Seven-day services

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

The hospice was open 24 hours a day, seven-days a week to support patients and family caregivers who required help with their care. Nursing and healthcare staff provided care to patients 24 hours a day. Patients and relatives said they were given as much help or privacy as they needed, whenever they needed it.

Nurses led daily patient rounds including weekends, and doctors led twice weekly patient rounds. Patients were reviewed by consultants depending on the care pathway. Consultants were available for advice and support seven-days a week. Consultants were available overnight and at weekends via telephone for escalation when a patient’s condition changed.

Staff could call for support from other disciplines such as chaplaincy and mental health services, 24 hours a day and seven days a week. Staff told us they found access to support easy and always available.

The hospice had access to a team of support staff to escalate building and equipment failures. The team were available Monday to Friday and an on-call service was available overnight and at weekends.

Health promotion

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

Staff assessed each patient's health when admitted and provided support for any individual needs to live as comfortably as they could.

Staff provided relevant information promoting living well to patients and family caregivers. The service supported patients and their loved ones by maximising their physical, mental health and wellbeing.

The service signposted people to specialist services and provided services they offered directly to people related to their life limiting condition. For example, the service provided mental health and wellbeing support to loved ones following the death of a patient. The service ensured ongoing support was provided through one to one discussions or group sessions, depending on the person's individual needs. This helped loved ones to grieve in a way that was personal to them, while having support through the first year after the death of their loved one.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were able to describe how they would support someone who lacked capacity to consent to care and treatment when required, which was in line with the Mental Capacity Act 2005.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. They made sure patients consented based on all the information available. Staff recorded consent in patient records.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Medical staff implementing do not attempt cardiopulmonary resuscitation (DNACPR) orders discussed this with the patient concerned and, where consent was given, with their loved ones. We reviewed five DNACPR orders and all showed staff had fully involved patients and their loved ones in the DNACPR decision.

We saw staff asked for consent for all interventions, for example taking physical observations. Staff explained the procedure to patients and family caregivers and made sure they felt safe to withhold consent when they wanted.

Are Hospice services for adults caring?

Outstanding ☆

We rated caring as outstanding.

Compassionate care

Staff consistently treated patients with compassion and kindness. There was a strong and visible person-centred culture. Staff were highly motivated to offer care that promoted and respected people's privacy and dignity. Staff took account of people's entire individual holistic needs.

People and those close to them continually provided positive feedback about how staff treated them well, with compassion and kindness. Their feedback showed a strong sense of a person-centred culture.

Staff were discreet and respected the totality of a patient's needs, including when a patient or those close to them may be afraid or feeling anxious. Staff took time to interact with them in a respectful and considerate way. We saw staff spoke gently and with kindness to patients and family caregivers in distress and those in pain or requiring immediate care.

Patients and family caregivers told us staff went the extra mile and exceeded their expectations. For example, the housekeeping team made sure a patient's shirt was washed and ironed when they knew the patient always liked their shirt ironed. The patient and family felt so touched and expressed their gratitude to the housekeeping staff in person. The family described how this filled a gap when they would normally do this but could not at a time when they were emotionally distraught. The family said how dignified the patient felt when they wore an ironed shirt especially when staff did this without the patient or family requesting it. This showed how staff considered people's specific individual needs.

We were given many examples where staff had gone above and beyond not only for their patients but also for their loved ones and family. The hospice was proud of this as its service was to provide patients and family caregivers a "home from home" stay. For example, arranging for pets to be brought in to say a final farewell, arranging for certain menu requests and arranging special family get togethers. The hospice had facilitated special occasions and blessings for patients and their family, often at very short notice.

We were given examples when staff continued to think about patients and their loved ones and, do things for them outside of their working hours. Patient and family needs were continuously thought of and staff had innovative ways to meet them. For example, a loved one described how staff had gone the extra mile. They commented, "the cottage hospice is a very peaceful and caring place which gave respect, dedication and care to my husband during his stay there. They also helped and cared for family members as well. A lovely little knitted heart, one for my husband and one for myself, which I keep on my bed post. It means a lot to have this knitted heart. I will always think of him and our lives we shared together. Thank you to all for your kindness". Another family caregiver said, "always there, always interested, caring emphatically, tolerant, consistent, attentive and when possible ready to go the extra mile".

Patient-centred care including loved ones was embedded in all staff working at the hospice. We saw staff had built strong and trusted relationships with patients and those close to them. Staff respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with physical and mental health needs. Staff treated patients and family caregivers with kindness and respect regardless of background or reason for attending.

We saw staff keeping promises such as returning to patients in a set time. We spoke with three patients and a family caregiver during the inspection and all reported nothing but positive feedback. They spoke of kind and dignified care, with staff who responded to people's needs no matter the time of day or business of the service.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff always made sure they referred to patient records and conversations about a patient's wishes when providing care.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. Staff recognised the impact of small gestures in supporting patients and those close to them. The service went above and beyond to ensure patients and those close to them had the emotional support throughout the final days of their life.

Staff consistently provided emotional support and advice to patients and those close to them. We saw the service had a culture where all staff provided emotional support to patients and those close to them regardless of role or seniority. Staff embodied this culture in their daily work routine.

Staff supported patients and family caregivers who became distressed in an open environment well and helped them maintain their privacy and dignity.

Nursing staff provided ongoing day to day emotional support through talking with patients and families. They recognised the need for families and loved ones to have their own space and time to talk, be emotional and grieve where a loved one was dying. Nursing staff recognised the importance of supporting this process; they gave people time and space and understood individuals cope in different ways and that not one approach fits all.

The chaplaincy service could provide spiritual and religious support to patients and those close to them. The service supported people to bring in religious leaders from other faiths outside the hospice and helped to coordinate their attendance.

Staff undertook training on providing emotional support and demonstrated empathy during difficult conversations. Patients and family caregivers said staff were sensitive when they discussed their wishes and preferred place of care or death.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The service continually emphasised a family caregiver's emotional needs were equally important to that of a patient. The service put both patients and their loved ones central to their care ethos and made sure people received the support they needed. They promoted support for patients as well as the needs of family caregivers. Staff made sure that family caregivers could have time away to themselves. We saw the hospice's "Informed" guide giving useful tips to family caregivers on how to look after themselves too. Topics included, "what it means to be a family caregiver and how to cope with fatigue and stress", "doing the 'right' thing" and "asking other people for help".

The hospice provided a confidential counselling services to patients and family caregivers when required.

The service provided family members and carers access to bereavement support. For example, they were re-starting "Tea Junctions" after the service put them on hold during the pandemic. These were informal social gatherings, where bereaved carers, family and friends got together so they could meet others who are going through a similar experience. The hospice also offered "connect and reflect", an online support group for those within the first year of their bereavement where people had the opportunity to meet others in a similar situation. The hospice counselling team facilitated these sessions.

The chaplaincy service held "first anniversary remembrance gatherings" throughout the year to provide spiritual support. This has enabled family members and carers mark the one-year anniversary of their bereavement.

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. Patients and those close to them were fully involved in their care. Staff consistently empowered people who used the service to have a voice and to realise their potential. Staff were fully committed to working in partnership with people and making this a reality for each patient.

There was a culture throughout the service that promoted a patient-centred approach. Staff made sure they involved patients and those close to them as much as possible, and wanted, in the decisions made about their care. Staff always consulted patients and family caregivers. The service provided exceptional end of life care and enabled people to experience a comfortable, dignified and pain-free death. Patient feedback we reviewed consistently supported this.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients and family caregivers told us they always had opportunities to express their views in their daily conversations with staff and knew who to contact if required.

Staff supported patients to make advanced decisions about their care. All patient records we reviewed showed staff discussed with patients and family caregivers their views, preferences and wishes about their future care. For example, staff discussed a patient's goals, the different treatments and refusal of any if people wish to and appointed someone to act on their behalf. Where appropriate, staff discussed a patient's preferred place of death and clearly documented this within a patient's records.

Patients and family caregivers gave positive feedback about the way staff consistently supported and involved them, and their family caregivers, to understand their condition to make informed decisions about their care. They said how staff took the time to sensitively explain about the resuscitation procedure and how staff gave them the space for their own thoughts. Patients and family caregivers never felt any pressure to talk and only at a time that suited them.

Patients and their family care givers were active partners in people's care. A family caregiver told us how staff fully involved them and met their wish when they gently guided them in washing their loved one on their final day of life. They told us how "useful" they felt and how staff made it a reality for them to get involved right to the very end.

Are Hospice services for adults responsive?

Outstanding ☆

We rated responsive as outstanding.

Service delivery to meet the needs of local people

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

People could self-refer to this service. The hospice also received referrals from GPs, the wider hospice care team, local hospitals and any health and social care provider. Managers planned and organised services so they met the changing needs of the local population. They tailored services to meet the needs of individual people and delivered the services in a way to ensure flexibility, choice and continuity of care.

The service recorded people's preferred place of care and death and used the information to tailor support for care of the local community. Along with this, the hospice used findings from the Dying for Change report by DEMOS, 2010 to develop the "home from home" stay service. The report talked about improving the conditions in which people die, in combining professional and family with formal and informal care in a more creative way. It is the knowledge of people's preferences and research work that led to the set-up of this hospice "home from home" care model. The service had embedded the use of information they collected about people's preferred place of care and death to improve services.

The environment was well designed, welcoming and well maintained. Facilities and premises were designed with the needs of the patients and family caregivers in mind. The suites provided a spacious setting for two; patients could independently mobilise if they wanted to, an extra bed could be placed together for family caregivers and a seating area including a dining table and chairs to enable families to eat together if they wished. The suites had floor to ceiling sliding glass doors that opened onto a private balcony equipped with a bistro table and chairs for two. Beds were positioned so patients could admire uninterrupted views to the large nature garden and countryside from their beds.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff had access to mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The hospice involved other organisations and the local community to plan services. They viewed this as integral to how services they provided could meet people's needs. They had innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with emergency care support needs. For example, they had an agreed care pathway with ambulance services for people who needed non-complex care to be admitted to this service instead of a traditional hospice or hospital which may not be a suitable environment.

Meeting people's individual needs

Outstanding ☆

Hospice services for adults

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

People's individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, provided choice and staff made sure there was continuity of care.

Staff used admission documentation that involved a full holistic assessment of a patient's individual needs. We reviewed three records and found staff had completed detailed information and clearly documented it.

The environment was designed to meet the needs of patients living with dementia; calm and quiet. As patients were predominantly in private suites they were encouraged to bring in items from home to personalise the suites and help reduce anxiety. There was good natural light in all suites and social spaces and the flooring was matte and not overly patterned. There was clear signage in contrasting colours in an easy to read font.

People using wheelchairs could easily access all areas, including a lift between two floors.

The leadership team showed a passion for offering equal access to service regardless of people's background. We found this ethos of providing high-quality personalised care with equal access transcended through all levels of staff within the organisation.

There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that meets these needs and promotes equality. The service met the needs of patients in specific circumstances, including those with protected characteristics. For example, there was a prayer room for people to use as a spiritual space regardless of religious beliefs. Staff said they would provide personalised care to patients regardless of their sexual orientation, gender or sex, or relationship status. Staff told us they would ask patients, or those close to them, how they wanted to be referred to and made sure this was communicated to all staff.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. They used communication aids to support patients and family caregivers become partners in their care. Staff had access to pictogram cards for patients unable to verbally communicate. This promoted the independence of the patient and allowed the patient to still have a voice, despite not being able to verbally communicate.

The service had information leaflets available in languages spoken by the patients and other languages in the local community if required.

Managers made sure staff, patients and family caregivers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The hospice offered a range of food for patients and allowed family caregivers or relatives to bring favourite food from home, if preferred. Patients were permitted to drink alcohol with dinner if they wanted to.

The hospice had no restrictions on visiting hours, and they encouraged family caregivers to stay overnight in the same suite as their loved one if they wished to. There were two separate guest rooms for additional relatives or carers if required. The service allowed pets to visit, as this was often important to patients and helped to keep them calm.

The hospice actively sought patients and family caregivers' views about their services when they were making changes. For example, they were planning to refurbish the individual rooms and, in preparation to make plans, had asked for patients and relatives views on what could be done to make their experiences easier. The hospice also offered easy-to-take foods such as ice cream and yoghurt which can be refreshing and pleasing.

Access and flow

Patients could access the service when they needed it. Waiting times from referral to admissions were monitored.

People can access services in a way and at a time that suits them.

The service had criteria for admission. Patients had to have non-complex care needs to be admitted. The hospice held a daily meeting seven days a week to review referrals and make decisions to admit either to this location or to their other hospice location which offered care for people who required complex care needs. Decisions to admit were also made outside the meetings for urgent referrals.

Managers monitored waiting times and made sure patients could access services when needed and received care within agreed timeframes. The service did not have a waiting list for admissions, at the time of inspection. They had 50% bed occupancy. Leaders told us the uptake of the service was slow as the pandemic had affected the new service when it was set up in December 2019. The provider continued to promote its 'home from home' service which was a new and unique hospice model unlike care offered in a traditional hospice.

The service did not move patients during the night, unless there was a clear medical reason or in their best interest. If required, staff would discuss it with a hospice doctor for agreement.

Staff undertook thorough holistic assessments of a patient's needs throughout their hospice journey, making sure their preferred place of care or preferred place of death was highlighted early. Staff used this information to put steps in place early so patients could get to their preferred place of care and preferred place of death.

The provider had access to its own community outreach team of nursing staff which were based at another location. The outreach team supported the rapid discharge of a patient into the community if their preferred place of care or preferred place of death was their own home.

Patient records we reviewed showed patients who required emergency end of life care support were admitted from their own homes in a timely manner.

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 included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Patients' feedback was consistently positive about how staff encouraged them to express their views, no matter how small an issue was. The service clearly displayed information about how to raise a concern through the hospice website and in relevant areas within the hospice such as the "Informed" guide.

Leaders actively reviewed complaints and how they are managed and responded to, and improvements are made as a result across the services. People who use services were involved in the review.

Staff understood the policy on complaints and knew how to handle them. Leaders investigated complaints thoroughly and identified themes.

Managers involved people who used the services in their review of complaints.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the hospice. Staff gave examples of how they used patient feedback to improve daily practice. The recommendations from the learning panels was used to inform changes to policies and procedures and staff talked about changes that had happened as a response to complaints. Since the service opened in December 2019, there had been no complaints regarding the care of patients or those important to them. The service received two complaints in March and May 2020 about early morning bin collections at this location, which woke nearby residents. The service liaised with the waste company and rearranged the bin collection time to ensure minimal disturbance.

Managers looked at the content of compliments as well to understand what the hospice did well and used this information as a potential improvement in other areas. Leaders said they viewed every complaint and compliment as an opportunity for getting things right.

Are Hospice services for adults well-led?

Outstanding ☆

We rated well-led 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, family caregivers and staff. They supported staff to develop their skills and take on more senior roles.

There was an established, stable and well embedded leadership structure at the hospice.

The senior leadership team was made up of the chief executive, medical director, care director, finance director, development and communications director, income generation and development director and two heads of service (one for this location and the other for Hospice in the Weald location). The medical director and care director primarily took the responsibility for overseeing clinical care delivery. The week prior to this inspection, the chief executive announced their retirement and the income generation and development director was appointed as the interim chief executive. The hospice planned to recruit to a substantive chief executive position later in the year.

The board was made up of 10 trustees who had the overall responsibility of overseeing the hospice business. They had an overview of the issues and challenges the service faced. Each committee was chaired by a trustee. This made sure the board trustees as a group could maintain the oversight of governance and safety in a structured and collective way.

This location was overseen by a head of service and a hospice manager. The head of service had extensive experience within hospice, palliative and end of life care. This enabled the head of hospice to provide managerial and clinical leadership, and support to staff. The hospice manager oversaw the day to day functions and provided managerial support to non-clinical staff.

Staff and people who used the service described they could call on any of the managers, at any time. Staff found the senior leadership team visible and they could approach them at any time.

Leaders made sure they prioritised safe, high quality, compassionate care and promoted equality and inclusivity. Staff described the leadership of the service as, “exceptional” and “most supportive and caring”. People described the service as a role model for other services.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a clear vision of, “celebrating life, dignifying death” and a clear statement of mission and values, driven by quality and safety. The mission was, “to provide compassionate, personalised and holistic care for everyone in our community living with a terminal illness, and for those important to them”. This was reinforced by their values, “honest, kind, learning, sustainable, ambitious and effective”.

The vision, values and strategy were developed through a structured planning process with regular engagement from internal and external stakeholders, including people who used the service, staff, local NHS trusts and clinical commissioning groups. Staff knew the business objectives and talked about how they aligned to their roles. The hospice values underpinned the work that all their staff and volunteers did.

The service had translated their vision, mission and values into a credible strategy with well-defined objectives that were regularly reviewed to ensure they remained achievable and relevant. For example, the hospice had updated their 2020 to 2023 business strategy. The refreshed strategy showed the hospice had considered the impacts of the pandemic and how that impacted timescales of their business objectives, including the wider health economy. The strategy and supporting objectives were stretching, challenging and innovative while remaining achievable.

The hospice leadership team and the board of trustees had the experience, capacity and capability to ensure that the strategy could be delivered. Strategic objectives were supported by quantifiable and measurable outcomes, which were cascaded throughout the organisation. Leaders understood the challenges and had an action plan to achieving the strategy, including relevant local health economy factors.

The relevant leadership experience and skills were maintained through effective selection, development and succession processes.

Culture

Staff felt respected, supported and valued. Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed. There was a strong culture of teamwork and support across all levels of the service. The service had an open culture where patients, their families and staff could freely raise concerns. Staff were focused on the needs of patients receiving care and shared a common goal to improve the quality and safety of care and people's experiences.

There were comprehensive leadership strategies to support delivery and to develop the desired culture. An example of a strategy was to empower staff to be the best they could be. Staff at all levels had the opportunity to develop and stepped into permanent and more senior roles.

There were high levels of staff and volunteer satisfaction across all equality groups. Staff described how they were proud to work for the hospice and spoke highly of the culture. Staff felt supported, valued and inspired to get to work each day to deliver truly personalised care for people. Some staff told us they were hesitant before the new model of "home from home" care was introduced in December 2019 because they thought they might deliver less personalised care. However, when the service started, they saw this was not the case. Feedback from patients and family caregivers consistently showed how they received "truly natural and holistic care" and how "they have thought of everything".

The leadership actively shaped the culture through effective engagement with staff, people who used the services and their representatives and stakeholders. We saw high levels of constructive engagement with staff and volunteers. Staff at all levels said they actively raised concerns. Concerns were investigated in a sensitive and confidential manner, and lessons were shared and acted upon. Staff told us examples where they had raised concerns and the leadership team had followed staff recommendations to make improvements.

Staff said candour, openness, honesty and transparency and challenges to poor practice were the norm. There was a culture of collective responsibility between teams and services. Incident related investigation reports we reviewed showed the service practiced candour when something went wrong. Patient records also supported this.

The service had mechanisms to support staff and promote their positive wellbeing. An example was the leadership team increased virtual engagements with non-patient facing staff during the pandemic. At the start of the pandemic, staff were offered a choice of where they wished to work and all staff got to work in their first preference out of three. Staff could also access counselling services if required.

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 was an effective governance structure. All meetings within the governance framework were well attended and this had worked well for years. Staff at all levels clearly knew their roles and responsibilities. There were clear lines of accountability throughout the hospice structure and all staff were clear about who they were responsible to and with whom to escalate problems.

The board of trustees and other levels of governance within the organisation functioned effectively and interacted with each other appropriately. Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective.

The hospice enabled and promoted open discussions at all levels about care delivered and potential improvements to offering care. The senior leadership team and trustees attended board meetings every quarter. Directors submitted reports containing performance, quality or incidents for each other and the trustees to interrogate. The senior leadership said the trustees would challenge the content of the reports where necessary. We saw this in the three board meeting minutes we reviewed.

The board meetings along with the monthly clinical governance committees, senior leadership team, weekly and daily operational meetings enabled open discussions and suitable scrutiny. This was shown in our review of the minutes of these meetings from November 2020 to July 2021. Quality received adequate coverage at board meetings and in other relevant meetings below board level. All the meeting minutes were clear, had defined outcomes and actions with staff ownership and clear timescales for completion.

The hospice had peer group meetings such as communications, health and safety and workforce consultative group to enable discussions about any good practice to be highlighted or concerns to be shared. Staff said these were invaluable to help open discussions and identify learning opportunities.

The board and senior leadership team made sure they proactively reviewed governance and performance arrangements and reflected best practice. They welcomed rigorous and constructive challenge from people who use services, the public and stakeholders and the senior leadership team saw this as a vital way of holding themselves to account.

Management of risk, issues and performance

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

The service had an effective and comprehensive process to identify, understand, monitor and address current and future risks. The hospice held a risk register and our review showed comprehensive information about the issues and actions they needed to take to help minimise the risks. All risks clearly had a staff responsible for overseeing the actions and clear timescales for review. Staff we spoke with could describe the main risks.

The service recognised their low occupancy rate as a risk. This was recorded in their risk register and described the actions the hospice had undertaken and continue to take to minimise the risk. For example, the service made sure they offered staff bespoke training to understand the family caregiver model better. This made sure staff could provide the right information to patients and their loved ones to make an informed decision. To support this, the hospice also developed the “Informed Guide” that explained how to provide basic care in easy steps. The service also encouraged potential patients and family caregivers to visit the hospice before they made their decision to stay. The hospice also undertook work to update their website with improved images and information to make it more user friendly and appealing. In addition, the service worked continuously with clinical commissioning groups, community services and acute hospitals to encourage and utilise this service. The service continued to monitor occupancy rates and discussed this regularly at senior leadership team and board meetings.

The hospice had nominated leads for areas such as infection control, safeguarding and finance. These leads reported on their areas at meetings and answered to the interim chief executive and trustees on the quality of the information they presented.

Performance issues were escalated to the relevant committees and the board through clear structures and processes. The leadership team was knowledgeable about quality issues and priorities, understood what the challenges were and took action to address them. Performance information was used to made improvements and to hold responsible staff to account.

The hospice had business continuity plans to cover various issues such as power loss and had mitigated risks such as performing routine servicing to backup generators.

The interim chief executive and care director oversaw all complaints. They assigned a lead to investigate a complaint. Investigation leads made sure they reviewed the content of complaints, compliments and concerns to drive improvements and to uncover any unknown risks.

The service undertook a systematic approach to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money.

Financial pressures were managed so that they did not compromise the quality of care.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service managed information well and kept patient records safe. There were systems and information to manage current and future performance. Information systems were secure and appropriate for use. For example, the electronic patient record system enabled data to be extracted and analysed accurately as all entries were automatically timed and date stamped. All staff we spoke with said they were confident in using the system.

Staff used information in reporting, performance management and delivering quality care. Staff undertook audits to make sure information they used is accurate, valid, reliable, timely and relevant.

Leaders proactively collected information and analysed it to drive improvements in care such as patient admission wait times from the time of referral. This showed the hospice actively sought opportunities to be efficient; with input from clinicians and finance to understand their impact on the quality of care. They also effectively monitored the impact on quality and financial sustainability.

The hospice had systems to manage safety notifications from outside agencies to keep patients and staff safe. They also submitted relevant statutory notifications to CQC and complied with requests for further information when required. The hospice also had systems to report to other agencies such as the yellow card reporting to the Medicines and Healthcare products Regulatory Agency and the local authority safeguarding teams, if required.

Information governance was part of the mandatory training for all staff and information showed 100% of staff had completed the training. Staff had knowledge of their responsibilities to comply with good information governance and management. IT systems were password protected and users had individual logins into each system. This enabled staff to maintain accurate and secure records each time they used a system and provided the service an audit trail of who accessed a system. We saw that computer screens were locked when staff were not using them.

The service gathered patient feedback and outcome measures, and we found relevant committees and groups reviewed this. The service used the information to implement learning and improvement. We found the multidisciplinary team, clinical group and clinical governance committee reviewed the Integrated Palliative care Outcome Scale (IPOS) and used the information to improve outcomes for patients and their families, and to demonstrate they provided effective palliative care. IPOS is a globally recognised tool used in delivering palliative care. It is a, “measure of global symptom burden which includes items that measure physical, psychosocial, social and spiritual domains in line with an impeccable holistic assessment. It allows patients to list their main concerns, to add other symptoms they are experiencing, and to state whether they have unmet information or practical needs”.

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.

The hospice used different approaches to gather feedback from people of all groups who used their services. All this feedback was reviewed; themes and trends were identified to improve the future service the hospice provided. The service conducted a survey “your experience of our care” every year. This consisted of eight quality questions ranging from rating the hospice overall care, supporting decision-making, information provided to managing symptoms and pain. Results from a recent survey showed five out of the eight quality questions, the service scored very high levels of patient and family caregiver satisfaction levels from 94% to 98% and the remainder three questions scored high levels of satisfaction from 84% to 87%.

Along with this, the hospice also used a research post to study the benefits of understanding the quality of care provided to patients and family caregivers in its first year of providing service. The service monitored its efficiency and effectiveness through setting measurable objectives such as occupancy rate, number of referrals, workforce capability and stability, and quality feedback.

The hospice asked its staff to complete a yearly staff survey and acted upon the results of these. We saw the 2020 staff survey showed improved satisfaction overall compared with the 2019 survey. Even though there was improved staff satisfaction, the service had identified opportunities for improvement such as communication, recognition and praise, morale and training and development; the business strategy included empowering staff and volunteers by increasing their capability and stability.

The hospice ran a joint staff and volunteer forum, that was chaired by a member of staff. They felt a joint forum provided integrated learning and support and provided volunteers a formal way of speaking and voicing their opinions with the organisation.

The hospice worked collaboratively with the local health and social care groups to deliver services needed in the areas they covered. An example is that the service worked collaboratively with the local NHS hospital to identify suitable patients for referral to the hospice as early as possible. This reduced the burden on frontline hospital staff and aimed to reduce hospital admissions for people near or at the end of life. The hospice had an increase in referral rates from 27% in September 2020 to 50% in August 2021.

The hospice also worked with NHS 111 and the ambulance services to make sure suitable patients were referred to the hospice instead of being taken to a hospital. This achieved the outcome of patients who had expressed a wish for their preferred place of care or death.

Learning, continuous improvement and innovation

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

There was a strong focus on continuous learning and improvement at all levels of the service, and commitment to learn from things that had gone wrong and gone well. The service regularly audited itself to benchmark progress. The leadership drove continuous improvement and there was a clear proactive approach to seek and embed new and more sustainable models of care. An example is the implementation of this pioneering service that offered “home from home” model for people at the end of life requiring non-complex care.

The hospice had developed an “Informed Guide” to empower family caregivers looking after their loved ones in their final days of life. The purpose of the guide was to lessen the anxiety of “I don’t know what to do”. Information in the guide was presented as a series of “pick up and put down” materials presented in both video and written format. Anyone caring for someone at the end of life could access the information; in their home, a hospital or a hospice. Patients and their family caregivers we spoke with commented, “very useful materials, such practical steps and tips to explain everyday tasks where I can get involved” and “easy to read and easily accessible”.

Leaders supported safe innovation and staff had objectives focused on improvement and learning. Managers encouraged staff to use information and regularly take time out to review performance and make improvements.

The hospice had a “people and workforce development strategy” which offered training and development opportunities for staff to learn as part of their role. All senior members of staff we spoke with had worked at the hospice for years and had been upskilled to take on more responsibilities and new roles. While the hospice understood the benefit of cultivating talent and providing staff new opportunities to retain them, they also recruited new staff with wider experience.

The provider worked in partnership with other organisations to ensure they provided a high-quality service. They established close links with the local authority and the local Clinical Commissioning Group (CCG) to create a federated scheme which included an accredited National Vocational Qualification (NVQ) centre. This centre provided opportunities for staff in local residential homes and domiciliary care agencies to study and gain qualifications in dementia and end of life care. This made sure people who received care and support in residential settings and in their own homes could be confident staff practice were relevant and met people’s needs. This centre also offered apprenticeships in health and social care.

The service had worked collaboratively with local hospitals, GPs, mental health services and the community to implement shared electronic records for patients in Kent and Medway. This was a new project and this way of sharing real-time information supported effective decision-making to provide coordinated care at the right time and place for patients and family caregivers.

Hospice staff had contributed to local and national conferences, events and projects to improve the lives of those with life limiting conditions and those at the end of life. Staff had carried out research into improving the experiences of patients at the end of life. Staff presented their work at the hospice to share learning and develop local services.