The Myton Hospices

Rugby Myton Hospice

Inspection report

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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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as good because:

- 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 made sure staff were competent for their roles.
- Staff used effective infection control measures.
- The, maintenance of equipment was in place to keep people safe. Staff had access to and completed training to use systems that managed clinical waste well.
- Staff had processes to complete and update risk assessments for each patient. Risk assessments consider patients that might be deteriorating in the last days or hours of their life.
- The service had enough nursing and support staff, with the right qualifications, skills, training and experience to keep patients safe from avoidable harm.
- The service had not had any patient safety incidents. Managers shared lessons learned with the whole team and the wider service.
- Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.
- Staff from the service worked with other healthcare professionals as a team to benefit patients. They supported each other to provide good care.
- Staff monitored the effectiveness of care and treatment.
- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff supported patients to make informed decisions about their care and treatment.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service planned and provided care in a way that met the needs of local people and the communities served. The service took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- It was easy for people to give feedback and raise concerns about care received.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced.
- Staff felt respected, supported and valued. However, they were focused on the needs of patients receiving care.
- Leaders operated effective governance processes, throughout the service and with partner organisations.
- 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 collected reliable data and analysed it. Staff could mostly find the data they needed, in easily accessible formats, to understand performance, however improvements to service provision were not always planned. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

However:

Summary of findings

- The service provided mandatory training in key skills to all staff but not all staff were up to date.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Good 	Our rating of this location stayed the same. We rated it as good overall because: We rated safe, effective, responsive and well-led as good. We did not inspect the key question of caring at this inspection. The previous rating of good remains.

Summary of findings

Contents

Summary of this inspection

Background to Rugby Myton Hospice

The Myton Hospices is a charitable organisation which aims to provide multi-professional specialist palliative care and end of life care to adults with terminal illness across Coventry and Warwickshire.

Rugby Myton Hospice provides services to people aged over 18 who are living with life threatening and life limiting conditions. The main service we inspected was the hospice at home service.

Professionals can refer patients to the hospice at home service which provides personal care to patients and families in their own homes in the last few weeks of life with the aim of supporting people where possible to die in their preferred place care. The services work in close liaison with all other community providers. The hospice at home service is to support people with palliative (Palliative care is comprehensive treatment of the discomfort, symptoms and stress of serious illnesses) and end of life care needs in their own homes. Family support is provided. The aims of the services offered include supporting people with their physical health and emotional wellbeing. The aims of the service are:

- To enable adults to remain at home regardless of diagnosis, if this is their choice
- To work closely with their key worker (usually a District Nurse) to plan the care required to provide seamless care
- To support discharge from hospital/hospice in the last few weeks/days of life, enabling preferred choice of place of care/death
- To support rapid discharge home to die from hospital for patients who are in their last days/hours of life
- To prevent unnecessary admissions to hospital/hospice in the last few weeks to days of life
- To improve the provision of psychological support and information for the carer
- To improve bereavement outcomes for carers.

The types of care provided by staff working within the hospice at home service were as follows:

- During the day experienced staff will visit and provide personal care
- Palliative Nursing Support for the whole family, providing emotional and psychological support, providing information, advice and reassurance as well as practical advice or training from the team.
- When night care is provided an experienced carer will be in the home from 10pm – 7am to provide care throughout the night.
- The Registered Nurse can monitor symptoms and liaise with the District Nurse/Palliative Care Clinical Nurse specialist/GP.

Data from the service showed that from April 2021 to March 2022, 89 patients were seen by the hospice at home service.

The day hospice is a purpose-built hospice based within the grounds of an NHS hospital. At the time of the inspection the day hospice service was being restructured and onsite services were not running but were scheduled to open in August 2022. The Myton at Home service operates out of the hospice site.

This means there was limited regulated activity being delivered from the day hospice at the time of inspection therefore we can report on the element of the service being provided at the time of the inspection. Our report is based upon our inspection of the hospice at home service, the elements of the day hospice being delivered alongside policies and procedures in place and the environment of the day hospice.

Summary of this inspection

There was a registered manager in post at the time of our inspection. The Myton at Home team comprised of a small team of nurses and nursing assistants. The location also had support from over 35 volunteers.

The service is registered for the following regulated activities:

- Treatment of disease, disorder or injury

How we carried out this inspection

We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed to seek assurance about this decision and to identify learning about the DMA process. The inspection team comprised of a lead CQC inspector, a specialist advisor with skills and knowledge in end of life care and was overseen by a CQC inspection manager.

We reviewed three records, observed one episode of care (over the phone) and spoke with two staff.

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.

Areas for improvement

Action the service SHOULD take to improve:

- The service should ensure that staff become compliant with mandatory training.
- The service should consider how staff can easily access ReSPECT forms so they were aware of patients' choice around resuscitation when they were not in the patient's home.
- The service should ensure that all patients who require interpreters are provided with these.
- The service should ensure the business continuity plan is reviewed and up to date.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Hospice services for adults

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

Are Hospice services for adults safe?

Good

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

Mandatory training

The service provided mandatory training in key skills to all staff but not all staff were up to date.

Not all staff received and kept up to date with their mandatory training. The service had a mandatory training and competency framework, compliance was monitored through a training database.

Data from the service dated 9 June 2022, we saw mandatory training compliance for patient facing roles at Rugby (six staff) ranged from 69% to 100% against a target of 95%. The average was 85% therefore at times below the provider target.

Modules where staff were non-compliant included moving and handling, infection prevention and control and basic life support.

We received an action plan that indicated four staff members were to receive infection prevention and control (IPC) and health and safety awareness training, as a combined course, in August 2022. Basic life support training was also planned to be facilitated in August 2022, to meet the provider training targets.

On the provider risk register, we saw a risk relating to the provision of face to face manual handling training to all staff. Actions were in place to mitigate this such as training staff to deliver the training in house in April 2022.

All competencies were reviewed on a regular basis to ensure that they met current guidelines and procedures and each competency document had a review date. In key areas such as moving and handling, champions had been identified to monitor the application of training in practice.

The mandatory training was comprehensive and met the needs of patients and staff. Whilst not part of the mandatory package, training to support patients with mental health needs, dementia, autism and learning disabilities was provided

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

Good

Hospice services for adults

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.

Nursing staff received training specific for their role on how to recognise and report abuse. Nurses and nursing assistants were trained to level two in safeguarding children and adults. The administrator was trained to level one. We saw all training was up to date except for two nurses who were out of date with level two safeguarding children.

The service had an up to date safeguarding adults and children policy which clearly identified different types of abuse including female genital mutilation and child sexual exploitation and how to recognise these. The policy contained a clear flow chart to direct staff to appropriate actions to take if abuse was suspected, with the contact numbers and addresses for the relevant agencies, including the local authority. This was available on the hospice intranet.

The Director of Nursing was the safeguarding lead for the organisation. We saw current certification showing that they were level 3 qualified. For level 4 safeguarding advice the provider accessed the lead from the local NHS trust.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. No services were provided to children however children may have been present in patients' homes at the times staff visited. Volunteers also received some safeguarding training to enable them to identify safeguarding concerns.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.All clinical staff underwent regular group safeguarding supervision. There was also 'ad-hoc' or 'in the moment' supervision by the safeguarding lead for staff who needed to discuss any aspect of the safeguarding process that is concerning them.

Cleanliness, infection control and hygiene

Staff used effective infection control measures.

All areas were clean and had suitable furnishings which were clean and well-maintained. Although there were no activities taking place at the time of the visit, we saw that the service had mechanisms in place to control infection risk well. Staff had access to equipment and control measures to protect patients, themselves and others from infection. The equipment and the premises were visibly clean. All areas of the building were observed to be clean and tidy as were the grounds and the gardens.

Staff had access to suitable equipment to enable them to follow effective infection control principles including the use of personal protective equipment (PPE). Patient areas we inspected were visibly clean, including the reception and waiting area. Staff were aware of the need to follow the arms 'arms bare below the elbows' protocol. We saw the availability of personal protective equipment (PPE) for staff to use and adequate access to handwashing areas.

Hand gels were readily available in all areas of the hospice. There were plenty of gel dispensers, aprons and various sized gloves, which were all fully stocked.

Due to the nature of the service, staff visited patients in their own homes it was not feasible to undertake specific audits such as hand hygiene audits. Staff were aware of the need to follow the arms 'arms bare below the elbows' protocol.

Clinical waste disposal systems were in place, which included sharps bins for the safe disposal of used needles and other equipment.

Policies and procedures were in place to reduce the transmission risk of COVID-19.

Staff could clean equipment after patient contact and there was a process to label equipment to show when it was last cleaned. The flooring used in clinical areas, enabled staff to carry out appropriate cleaning and maintain a suitable level of hygiene required between uses. This would reduce the risk of cross infection. We saw cleaning rotas were in place to ensure regular cleaning could be undertaken and housekeeping staff could sign off areas that had been cleaned.

Environment and equipment

The, maintenance of equipment was in place to keep people safe. Staff had access to and completed training to use systems that managed clinical waste well.

Please note at the time of our inspection, the day centre was not being used by patients.

The design of the environment followed national guidance. In preparation for the start of regulated activity, the building had a fire alarm system installed and we saw from records that this and firefighting equipment was regularly maintained and replaced when necessary. We checked a sample of some firefighting equipment and they were all within their next service dates.

Where home visits were completed were in place for a range of aspects including equipment in the home, hazards, parking, pets, and smoking.

Staff carried out safety checks of specialist equipment.

All portable electrical equipment had been serviced and tested within the last year, in preparation for services to resume. Equipment safety checks were undertaken in line with local policies. These included checks of resuscitation equipment.

We saw a schedule of clinical equipment maintenance was in place for this service. This showed all clinical equipment had been serviced during 2022. This equipment included two suction pumps, a nebuliser, two sphygmomanometers, a thermometer, and a digital blood pressure monitor.

The service had suitable facilities to meet the needs of patients' families. Although not in use during the visit, there were areas for families to go to if they needed to be on their own. They could access the garden and patio area, also, an area was available to speak confidentially to councillors in private offices.

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

A defibrillator was situated on the outside of the hospice.

The hospice had a supply of oxygen should people need this in an emergency.

An anaphylaxis kit was available in case of emergency allergic reactions.

Staff disposed of clinical waste safely. A process was in place for clinical waste and domestic waste bins to be emptied by the cleaning staff and disposed of in accordance with the waste disposal policy and procedures.

Good

Hospice services for adults

Assessing and responding to patient risk

Staff had processes to complete and update risk assessments for each patient. Risk assessments consider patients that might be deteriorating in the last days or hours of their life.

Staff could complete assessments for each patient, using recognised tools, and review them regularly. Staff had access to the Individual Palliative Outcome Scale (IPOS) to assess patients' needs, and the Australia modified Karnofsky performance Scale (AKPS) to identify if patients had any requirements relating to self-care.

Staff knew about and dealt with any specific risk issues.

Staff could access and complete risk assessments for patients, these included COVID-19 risk assessments, falls assessments, mobility assessments, moving and handling and wound care assessments. Some risk assessments could be completed in advance, by referring clinical staff.

Some emergency equipment such as suction, oxygen and an anaphylaxis kit were available at the day hospice.

Systems were in place to manage deteriorating patients appropriately. A procedure was in place to describe what to do if a person became unwell. If considered to be an emergency staff either at the day hospice or in a patient's own home staff would dial 999 and ensure appropriate support was offered to the person. For patients at home who required less urgent medical attention staff would contact their GP or other healthcare professional relevant to their condition.

Key information to keep patients safe could be shared when handing over the care to other people. Staff had processes to work effectively with other professionals and care givers, district nurses. Staff could regularly share information though daily informal discussions and through structured multi-disciplinary meetings.

Staffing

The service had enough nursing and support staff, with the right qualifications, skills, training and experience to keep patients safe from avoidable harm. A process was in place for managers to give voluntary staff a full induction.

The service planned for enough nursing and support staff to keep patients safe. Data from the service showed the service had eight members of staff including the manager, two nurses, one clinical nurse practitioner, two nursing assistants and an administrator in post, this included staff who were to work in the day hospice when it reopened.

Managers could accurately calculate and review the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance.

Staffing levels were put in place in relation to the number of visits planned and the needs of each patient being visited.

The managers could adjust staffing levels daily according to the needs of patients. Staffing levels were planned for and adjusted according to the number of visits required. The plans for the day hospice was that patients would attend on a sessional pre booked basis to enable staffing numbers to be planned.

Staffing levels were sufficient and flexible enough to allow rapid discharges to enable patients to be cared for in their own homes.

The service had low and/or reducing rates of bank staff.Managers limited their use of bank staff and requested staff familiar with the service. To fill any gaps in staffing the service flexed the use of staff from other registered locations they provided. Some bank staff were also recruited and used to cover staff absence.

Managers made sure all bank staff had a full induction and understood the service.

The service used volunteer staff to support delivery of patient care at the hospice. A policy was in place outlining a process for recruiting and managing volunteers. This outlined the induction, training and review process for volunteers.

Records

Staff had processes to complete and update risk assessments for each patient. Risk assessments consider patients that might be deteriorating in the last days or hours of their life.

Patient notes were comprehensive, and all staff could access them easily. Patient records were electronic. Staff had access to an up to date policy on managing patient records. We looked at three patient records which were kept up to date.

ReSPECT forms (Recommended summary plan for emergency care and treatment) were kept with the patient in their homes. However, staff told us that they could not always access the information in these records when they were in the office.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff could access community records to ensure information sharing.

Systems were in place for records to be stored securely. A policy on the storage and retention of records was in place. Records were stored securely; often electronic records were used which were password protected. No recent records audits had taken place to assess the quality or storage of records.

Medicines

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

Whilst the service was not currently providing a day service, there were processes in place to ensure medicines were managed safely. No routine medicines were stored onsite at the day service. People brought in their own medicines for use whilst they were at the hospice.

Oxygen and an anaphylaxis kit was on site for emergency situations. Adrenaline was in date and oxygen cylinders were secured to the wall and appropriately full.

We reviewed the anaphylaxis policy and procedure which stated nurses who may be required to administer drugs for the treatment of anaphylaxis will receive education/training as part of their induction and attend an annual update on the procedure of an anaphylactic reaction.

We saw there was a patient group direction (PGD) for the administration of intramuscular adrenaline. PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber).

Good

Hospice services for adults

We saw the PGD documentation was signed by the prescriber and the pharmacist but had not been signed by the nurses who would administer this as is best practice. However, we acknowledged that at the time of the inspection, the day centre was not open therefore staff would not need to administer this medicine.

Incidents

The service had not had any patient safety incidents. Managers shared lessons learned with the whole team and the wider service. If things went wrong, staff would apologise and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff were familiar with reporting systems on how to report incidents but had not had to do so.

Managers had systems to share learning with their staff about never events that happened elsewhere. Whilst there had not been any never events or incidents to share learning from there were forums and meetings in place for this to take place if required.

Staff understood the duty of candour. However, there were no incidents where this had been required to be followed.

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

Staff had the opportunity to review and reflect upon patient deaths during regular multidisciplinary calls between the service, the local NHS trust and other support services. This enabled staff to identify learning and to share feedback. There was learning shared from incidents that occurred at the providers other locations through clinical governance meetings. However, this was not documented in team meeting minutes.

Are Hospice services for adults 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.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance. Staff had access to a suite of policies and procedure to support them when carrying out their role. We reviewed a sample of these during our inspection and found they were based on up to date guidance.

At multidisciplinary meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed that staff referred to the holistic needs of patients and considered appropriate methods of psychological support.

Nutrition and hydration

Due to the nature of the service, the provision of food or drink was not necessary at the time of inspection. Staff considered patients' dietary needs as part of holistic assessments.

Staff spoke to patients about their diet in order to optimise the patients' physical wellbeing. Staff spoke with patients using the hospice at home service regarding their food intake and diet as part of their assessments.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

Staff assessed patients' pain and supported them to take pain relief but did not administer this. Staff asked patients about their pain levels and supported patients to manage this. This was usually through consultation with doctors or other healthcare professionals. Patients or their families managed medicines as care was received in patients own homes.

Patients managed their own pain-relieving medication if they were to attend the day service as no medications were kept on site.

Patient outcomes

Staff monitored the effectiveness of care and treatment.

The service monitored the number of patients using the service.

Data from the service showed that from June 2021 to May 2022, 89 patients were seen by the hospice at home service. Seventy-nine of these patients were new patients. Staff undertook a total of 1250 visits in this timeframe. Currently four patients were receiving a service, the number and timing of visits varied according to patient need. The majority of these visits (1159) took place in the daytime. Ninety-one visits took place overnight.

The number of discharges and deaths in this time period totalled 73. Discharges due to death totalled 69, with other discharges totalling four.

The service monitored the types of visits delivered and whether these were by patients or family members. For example, 2021-2022 figures showed 12 family members accessed counselling services through this location in this time period. Three patients used the counselling services in this time period, four patients used complementary therapy services, 11 patients saw the service for fatigue and breathlessness, one patient for living well services, two for wellbeing and 20 for general outpatient services.

Outcomes for patients were consistent and met expectations.

A dashboard was available which monitored the number of referrals, the input by the hospice at home service and the discharge figures. The overwhelming majority of patients were supported at home until they died indicating palliative care was provided fully. It was not recorded however how many died at their preferred place of death.

Managers and staff carried out a programme of repeated audits. An annual audit programme was in place which covered a range of areas such as: infection control, hand hygiene, tissue viability, pain chart compliance and mouth care. We requested the results and actions plans relating to audits and received a medicines and records audit. These were organisation wide and included actions plans.

Managers collected data to monitor care and treatment.

Data on where patients died was collated. Some data was collected on the duration of episodes of care. This showed the majority of care episodes, 26 out of 36 were less than 14 days duration..

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. New starters were required to undertake an induction programme prior to working with patients.

Managers supported staff to develop through yearly, constructive appraisals of their work. Six of seven staff had received an appraisal between September 2021 and April 2022. All staff who were in work and present had received an appraisal as the seventh staff member had been out of the workplace for some time.

Managers recruited, trained and supported volunteers to support patients in the service. The service had a team of volunteers who supported service delivery. Suitable recruitment policies were in place which were committed to equality and diversity principles. Consideration was given to the circumstances of the volunteers when deciding where they would be best placed. Volunteer handbook and inductions checklists were available.

Multidisciplinary working

Staff from the service worked with other healthcare professionals as a team to benefit patients. They supported each other to provide good care.

Staff worked very closely with the patients' district nursing team, and GP, to provide the hospice at home service.

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. On weekdays, staff attended a 15-minute call with other local hospices and the palliative care team at the local NHS trust. This enabled sharing of information about any urgent discharges from hospital to home, to discuss any concerns and to highlight capacity problems.

The service held fortnightly MDTs to discuss new referral patients, any patients who had passed away and any previous patients discussed the previous meeting. These were chaired by a palliative care consultant and was attended by nurses, psychology services and other support services.

In addition, staff at the service had a weekly scheduled call with the NHS community nursing team in order to identify new referrals, discuss current caseloads and to provide mutual support.

Staff worked across health care disciplines and with other agencies when required to care for patients. We saw staff spoke with patients about additional support in order to refer onwards where appropriate. This included counselling services, physiotherapy and complementary therapies.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Patients had access to counselling services through the hospice.

Seven-day services

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

Good

Hospice services for adults

The hospice at home service was available 365 days of the year, day and night. Daytime working hours were from 9am to 5pm. Night-time hours were from 10pm to 7am.

At the time of the inspection the day hospice service was being restructured and onsite services were not running. There were proposals to re-open Monday – Friday 9.30am – 4pm excluding bank holidays in August 2022.

Health promotion

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

The service had relevant information promoting healthy lifestyles.

A range of leaflets relating to healthy lifestyles, different medical conditions and sources of support were available in the reception area. Folders were provided to enable people to keep information together.

Staff assessed each patients' health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff were able to refer patients for support for specific aspects of health such as lymphedema management and counselling.

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.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff had access to an up to date policy on consent which covered the Mental Capacity Act.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff seeking consent from patients to have discussions about their needs.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Where patients had a lasting power of attorney in place for health (LPA) which enabled a designated person to make decisions on behalf of the patient, staff worked with the designated person to act in the patient's best interests. Where the patient lacked capacity to make specific decisions for themselves care would be delivered in line with best interests and there were multi-disciplinary meetings to discuss decision making.

Staff made sure patients consented to treatment based on all the information available. We observed staff explaining to patients about the service that was available to them to enable them to make decisions.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were not required to deprive patients of their liberty in this service due to the nature of the service.

Good

Hospice services for adults

Are Hospice services for adults caring?

Good

Our rating of caring stayed the same.

We did not inspect this key question at this inspection. The previous rating of good remains.

We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed to seek assurance about this decision and to identify learning about the DMA process.

Are Hospice services for adults responsive?

Good

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

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population. There was a comprehensive standard operating procedure for the hospice at home service. The hospice at home service was accessible to people with palliative) and end of life care needs in their own homes (palliative care is comprehensive treatment of the discomfort, symptoms and stress of serious illnesses. Family support was also provided. The aims of the services were to people with their physical health and emotional wellbeing.

The service was planned in consultation with the local NHS trust's palliative care team to ensure patients received a joined-up service alongside other healthcare providers.

The planned support hub (day hospice) due to open after the inspection was largely going to be accessed by people on a sessional booking basis. This ensured that numbers attending was monitored. Patients could self-refer in the hope was that by engaging with patients at an early stage they would be more likely to use hospice services nearer the end of their palliative care journey.

Transport was not routinely provided however volunteers were available to transport people.

Facilities and premises were appropriate for the services being delivered. All patient facilities at the day hospice were located on the ground floor providing full disabled access. Designated disabled parking was available. The hospice was accessible by public transport.

There was limited equipment bariatric (for heavier patients) available at the day centre. Some equipment had been loaned to other services during the pandemic. However, as the day centre service was not running at the time of our inspection; this was not a significant concern. After our inspection the provider informed us that equipment was now available.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff could refer patients, and their families, to additional services such as complementary therapy and psychological support services.

Meeting people's individual needs

The service 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.

Staff made sure patients living with mental health symptoms, learning disabilities and dementia, received the necessary care to meet all their needs. Staff referred patients to psychological services where this was identified as a need. The hospice at home service was accessible to all groups of patients as they had a prognosis of being in the last weeks or days of life.

The operating model for the day hub which was due to commence in August 2022, stated that people with mobility or care needs would be asked to attend with a family member or carer to meet these needs. Patients who required support due to a learning of mental health condition would also be able to access support with carers.

Personal care was provided as part of the hospice at home service however it was not planned to be offered as part of the day service.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Staff could access interpretation services for patients who did not speak English. However, staff told us they would usually use family members to interpret. This is not best practice as complex medical information may not be understood or accurately reported on by the person interpreting this.

Staff had access to communication aids to help patients become partners in their care and treatment. The assessment process asked patients about their hearing, main language, and any speech and language disorder so that communication barriers could be identified and addressed.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

A professional referral was required for the hospice at home service, for example by a palliative care specialist nurse or a district nurse.

The referral criteria for the hospice at home service included:

Good

Hospice services for adults

- All patients must be 18 years of age or older and registered with a GP practice within Rugby, Leamington Spa or Warwick at the time of referral.
- Patients can be referred regardless of diagnosis. They should have a prognosis of short weeks/days of life and have palliative care needs.
- Patients must have expressed a wish to choose to die at home and family/carers must be in agreement and able to support this.
- The patient, family/carer agree that the patients care needs are appropriate to being met at home.
- The patient must consent to the referral (or main carer if the patient does not have capacity to consent).

The service worked flexibly to meet patients' needs. Patients could receive support at home through a variety of ways for example, staff could attend in person, or could telephone patients. Patient visits could be planned in advance or be responsive to urgent patient need.

Managers monitored waiting times and made sure patients could access emergency services when needed.

There was not a waiting list at the time of inspection and referrals were assessed daily to ensure a timely response. Staffing provision allowed the hospice at home service to be available where patients were fast tracked for discharge.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service had not received any complaints however there were system to share lessons learned with staff.

The service clearly displayed information about how to raise a concern in patient areas. The service had mechanisms in place for patients to make a complaint. We saw a poster used to advertise this. Feedback was routinely sought about the service.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. However, no complaints had been received so we were unable to assess how they would be handled.

Managers had systems to share feedback from complaints.

No complaints had been received by the service. There were systems in place such as team meetings and governance structure to monitor any compliments, complaints and share learning.

Are Hospice services for adults well-led?

Good

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

Leadership

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

Good

Hospice services for adults

As the provider is a charity it was overseen by Trustees who shared responsibility for governing and directing how it was managed and run. The trustees came from a range of backgrounds and collectively had relevant experience to bring a range of skills to the running of services.

A provider wide senior leadership team provided oversight above local level; with an organisation board in place to provide corporate oversight.

The local structure of the service was made up of a service hub manager who was supported by a senior staff nurse. They oversaw nurses, nursing assistants and an administrator. A provider wide 'Myton at Home' lead oversaw the hospice at home service.

The local management structure was responsible for running the service and managing the staff.

Staff told us support was available from other staff and managers. Staff were able to contact someone for advice when needed.

Managers were visible to staff and supportive to them. Leaders were currently focused on post COVID-19 recovery plans and getting services running again. Leaders we spoke to were passionate about the services being provided and forward looking to the new day hub provision.

The provider had other hospice services in the area and there was a close working relationship and corporate oversight of these.

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.

A provider wide vision was in place. The overarching vision was that all people across Coventry and Warwickshire had the right to a good, natural death, the way they wanted it to be and with their loved ones supported.

The provider mission was to provide high quality, specialist care to people whose condition no longer responds to curative treatment, from diagnosis to death. The service aimed to meet their physical, psychological, spiritual and social needs and ensure their families are supported both through and after the patients' death. The service also provided training and support to other care providers to practice good palliative care.

The services values were:

- One Myton, one team, one goal - delivering holistic care.
- Professional in all we do.
- Respect and dignity for all.
- Value every individual and ourselves

Good

Hospice services for adults

The leadership team discussed the provider wide strategy regularly at board meetings. The current strategy was under review with an aim to develop a new strategy for 2023 to 2026. Organisation priorities had been identified to support the current strategy up until 2023 which included: health and wellbeing of staff, increasing bed availability for the locations with inpatient units and rebuilding the volunteer team.

At the time of our inspection the hospice at home service was operational however the day service was not running. This was under review and a standard operational procedure had been drawn up in May 2022 with a vision that a new type of hub model would commence in August 2022. Within this roles and responsibilities of leaders were described.

The aim of the hub model was that it would work in partnership with other organisations and offer a range of services to people living with or affected by a life limiting illness.

Culture

Staff felt respected, supported and valued. However, they were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Minutes from recent board meetings showed that staff wellbeing was on the agenda for leadership. Leaders discussed staff feedback about some feeling less valued and having less support as the service moved out of the pandemic. Actions to engage with staff to identify suitable support going forward were discussed at board meetings. Team meetings also minuted discussions around valuing and supporting staff.

Leaders and staff were passionate and positive about providing good quality care to patients.

Procedures were in place to protect lone working staff.

No complaints had been received from patients or their families however positive feedback had been received.

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.

The service fed into a provider wide governance process. Regular board and clinical governance meetings were held, and we saw there was representation at both meetings from the same individuals to ensure information could be escalated and cascaded within these forums.

We saw minutes from a provider wide board meeting which had standing items on the agenda such as the corporate risk register and clinical governance. The attendees discussed policy updates and changes. Board meetings were held every other month.

Managers at the service held regular clinical governance meetings. These were provider wide and the minutes we reviewed did not contain specific detail at a location level. However, we saw evidence of shared learning from incidents at other services such as following drug errors.

The provider had groups that fed into the clinical governance meetings such as tissue viability and falls groups.

During our inspection we found the policy for cardiopulmonary resuscitation was out of date in the emergency cupboard. However, this was rectified during the inspection. It had been reviewed; it had just not been replaced therefore an up to date version was produced. There were no patients on site at the time of our inspection.

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.

We reviewed the corporate risk register in place at the time of inspection. The risks identified related to the providers overall services and were not always relevant to this location; although some general risks applied such as the impact of increased home working during the pandemic on staff wellbeing, and a lack of face to face manual handling training. We saw actions were in place to mitigate these risks.

The provider monitored quality and performance in terms of incidents reported and their severity, complaints, audit results and training compliance for staff. Data from the service was provider wide so did not always allow for location scrutiny.

A provider wide audit schedule was in place for 2021 to 2023. We saw completed audits; and where delays in the audit programme had occurred; this was clearly documented.

The provider had a business continuity plan in place however this was out of date at the time of inspection; it was due for review in September 2021.

The service provided one set of staff meeting minutes for May 2022. These showed staff discussed items such as staffing, training, complaints, staff engagement and events that could interrupt the service. We saw the team discussed sharing learning from incidents.

Staff recruitment records were provided to us which included DBS checks and references and showed that proof of identity for staff was checked.

Finances and funding of the hospice was discussed regularly at clinical governance meetings. The focus was to get services up and running now that the restrictions of COVID-19 were easing.

Information Management

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

The service had an up to date policy around the destruction of non-clinical records. This outlined the time frame for retaining documents; and methods of safe disposal.

A range of paper and electronic records were used. All were securely held. The provider held some performance data but it was not always clear that this was used to improve services.

The service submitted statutory notifications to CQC in line with the CQC Registration regulations.

Good

Hospice services for adults

Engagement

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

We saw patient feedback had been sought specific to the counselling programme offered by the provider. The feedback was overwhelmingly positive.

There had not been a bereavement survey of friends or families conducted in the past year.

There was recognition that some Black, Asian and Minority Ethnic (BAME) communities were reluctant to engage with palliative care services. As a response to this some work had been undertaken to reach out to the Sikh community to improve engagement

The provider engaged with community-based organisations such as a Coventry and Warwickshire hospice network. The provider also engaged with the local NHS trust to improve communication and referral pathways.

We saw the service had engaged with the public about the re-opening of the day hospice service in order to identify if there was a need for the service. Out of 105 respondents, 103 said they agreed this service would meet the palliative care needs of people who may use the service.

Managers at the service engaged with staff to identify areas of concern or improvement. This was discussed at a team meeting.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

At the time of our inspection, the service were aiming to re-open the day hospice service which had been dormant due to the COVID-19 pandemic.

As part of a clinical governance meeting in October 2021, we saw a research nurse had been funded for one year. Actions were set to increase staff awareness and involvement in research.