

Dove House Hospice Limited

Dove House Hospice

Inspection report

Chamberlain Road
Hull
HU8 8DH
Tel: 01482784343
www.dovehouse.org.uk

Date of inspection visit: 14 December 2023
Date of publication: 09/02/2024

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?		Outstanding	
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:

- 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 managed 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 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, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients 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 planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- 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

End of life care

Rating

Good



Summary of each main service

Our rating of this location stayed the same. We rated it as good 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 managed 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 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, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients 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 planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- 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

Summary of findings

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

Contents

Summary of this inspection

Background to Dove House Hospice

Page

6

Information about Dove House Hospice

6

Our findings from this inspection

Overview of ratings

7

Our findings by main service

8

Summary of this inspection

Background to Dove House Hospice

Dove House Hospice provides specialist care for people living with a terminal illness. The service was registered with CQC in October 2010 and was last inspected in April 2015.

The hospice works with other partner organisations to provide high quality care to patients and their families. Funding is provided by the local NHS, charitable donations and grants. The hospice also provides training and education to local support groups.

The service cares for patients at the hospice location, it provides care to adults through inpatient services, day hospice and respite. Bereavement and counselling services are also provided to patients and their families.

There was a registered manager in post and the service is registered to provide treatment of disease, disorder or injury and personal care.

How we carried out this inspection

We carried out an unannounced comprehensive inspection on 14 December 2023. The inspection team consisted of 2 CQC inspectors and a specialist adviser with a background in palliative and end of life care. We looked at all key questions including safe, effective, responsive, caring and well led.

During the inspection we spoke to 20 members of staff, 6 patients and their families and we reviewed 8 sets of patient notes and 5 staff files.

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 **MUST** take is necessary to comply with its legal obligations. Action a service **SHOULD** take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service **SHOULD** take to improve:

The service should ensure that all medicines administered are recorded accurately in line with policy.

The service should continue with their plan to implement the National Standards of Healthcare Cleanliness 2021.






Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
End of life care	Good	Good	<div>☆ Outstanding</div>	Good	Good	Good
Overall	Good	Good	<div>☆ Outstanding</div>	Good	Good	Good

End of life care

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

Is the service safe?

Good 

Our rating of safe improved. We rated it as good.

Mandatory training

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

Staff received and kept up to date with their mandatory training. All staff spoke positively about the training programme. The clinical educators and managers monitored mandatory training using an electronic system and alerted staff when they needed to update their training. Staff told us if they fell behind with their mandatory training, managers would receive notification of this and would speak to them to arrange a time for completion.

Volunteer staff had their own mandatory training modules, which had been completed by all. New staff were provided with a comprehensive induction, which included a programme of orientation and basic skills needed to fulfil their roles.

Mandatory training was split into job roles and staff had personalised lists of training for them to complete. Mandatory training rates were 100% across the board for all permanent staff. The exception to this was for bank staff where the compliance rate was 86% at its lowest. However, this does not provide an accurate reflection as this relates to only 7 members of staff in total, therefore only 1 had not been completed at the time of the inspection.

The service had effective systems to monitor staff's compliance with mandatory training. Dashboards had been created within the electronic system to enable ease of reporting and also allowed them to track, analyse, measure, and readily access data when required.

Training was delivered as a mixture of face-to-face training and online completion by staff. Training modules included information governance, fire safety, health and safety, RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) and COSHH (Control of Substances Hazardous to Health Regulations), equality, diversity and human rights, safeguarding children - level 2, safeguarding adults – level 2, medicines safe handling and awareness, prevention and control of infection level 2, delirium modules and outcome measures. The online training included questions at the end of the course to help embed the course content.

End of life care

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia. While, within the clinical essential education, staff completed the module 'Mental Health, Learning Disability and Autism', to add to this, clinical staff completed Oliver McGowan training online. Identified key staff went on to complete level 2 following this. Competencies included administration of medicines and subcutaneous infusion.

Team Days were conducted quarterly in which, members of the executive leadership team, chairman and external experts attended. All staff were offered loss and bereavement training regardless of whether they were clinical or non clinical.

The service was keen for staff to develop their knowledge and skill sets and had established strong links across the system for learning and sharing. For example, they ran an external training programme which was aimed to diversify and to support the existing and future health and care workforce. Virtual and in person learning events covering palliative/end of life care (EoLC), loss and bereavement, learning and living with dementia and promoting wellbeing for health and social care practitioners had also raised funds for the hospice.

In September 2021 funding was secured to develop and deliver a bespoke training network to local hospital trust staff supporting people living with dementia.

Hospice School was delivered in person during the summer of 2022 to 6 participants and 10 participants in 2023, the 2 day course is an opportunity for students aged 16-19 to develop essential care and communication skills that are transferable to any health and care environment. Hospice School provided the opportunities to learn hands on care skills, as well as meet and speak to experienced health and social care professionals from across the organisation.

They provided a virtual work experience consisting of 4 tiers which ranged from introducing values and soft care skills, applying knowledge to real life care examples, developing care plans and meeting the professional they were aspiring to become (e.g. students applying to be medics met with one of the Dove House Doctors). Local students gained 1,500 work experience hours from undertaking the virtual work experience programme and 250 students completed Tier 1. The pilot was very successful, and they were given the opportunity to showcase this at a national webinar for NHS England.

Completion of mandatory training was linked to staff appraisal and any gaps were discussed and action was taken to ensure training was booked and completed.

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.

Staff received training specific for their role on how to recognise and report abuse. Staff received training in safeguarding adults and children. The completion rates for safeguarding children and adults at all relevant levels was 100% across the board. The exception was for bank staff which was at 97%, however this equated to just 1 member of staff.

Staff had the appropriate level of safeguarding training for their role and could recognise the signs of abuse. We heard that safeguarding training was carried out face to face to use real cases from the service and to ensure staff are supported well when discussing sensitive matters.

Level 1 Children and Adults training was carried out by all non-clinical staff and volunteers including their board of 10 trustees.

End of life care

Training at level 3 included the training required at levels 1 and 2 and negated the requirement to undertake refresher training at levels 1 and 2 in addition to level 3. Training refresher dates were 3 years for all roles as recommended in national guidance.

Clinical new starters undertook level 2 online safeguarding children and adults modules prior to commencing in role then arrangements were made for them to complete the level assigned to their role. The safeguarding lead attended the induction days for new starters to provide an overview of the service's approach to safeguarding and to communicate the role of the freedom to speak up guardian.

The family support team (psychosocial services including child bereavement), members of the executive leadership team, sisters, senior sisters and head of nursing, therapies & quality had all completed Safeguarding Children Level 3 and Safeguarding Adults Level 3 as part of their essential education. The safeguarding lead had completed Safeguarding Adults level 4 and Safeguarding Children level 4 as part of their essential education.

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. Staff said they felt confident to recognise and raise issues with their managers and knew when they should make referrals to the local authority. The hospice had a safeguarding lead and staff were able to name the lead and knew how to contact them.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They gave us examples of when they had raised safeguarding concerns and how they had actioned them. We saw evidence that safeguarding concerns had been discussed at staff meetings and actions agreed. The service also had a team meeting with social workers and were based on site where staff could access advice and support.

The service had a Safeguarding Children and Protection of Vulnerable Adults policy which staff can access to through the intranet. These policies included local authorities contact details for reporting concerns including out of hours reporting, links to online risk or concern forms and details of the 24/7 consultation line to access advice and guidance regarding safeguarding matters.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on wards and transporting patients after death.

All areas were exceptionally clean and had suitable furnishings which were clean and well-maintained. During our inspection we saw the housekeeping team working and checking all areas were clean.

At the time of our inspection, cleaning audits were not formally completed. They were done informally during daily ward walk rounds by senior and junior sisters and weekly with the senior sister with responsibility for infection prevention and control (IPC) and a senior member of the support services team. The lead for IPC also carried out IPC audits and found for example, the hand hygiene audits were constantly showing 100% compliance.

As part of the service's review of processes and to ensure continuous improvement they were implementing the National Standards of Healthcare Cleanliness 2021 (NSoHC). This was planned to be in place for patient areas from January 2024 and include non-patient areas by April 2024. This included documented audits of cleaning standards showing actual vs. target percentages with plans in place for any remedial actions identified. During the implementation of the NSoHC the service would display cleaning scores as a percentage.

End of life care

At the time of the inspection, areas had been assessed and assigned a functional risk. A cleaning specification has been developed based on these functional risk categories which provided information on how cleaning was carried out. Responsibilities for cleaning were shared between clinical and non-clinical staff including housekeepers, maintenance, and catering teams. This was recorded on a cleaning responsibility framework which was then to be reviewed annually as a minimum with any changes incorporated into their communication plan.

Whilst cleaning standards were very good, current cleaning records detailed the day-to-day cleaning completed by housekeepers only. The newer system will include cleaning completed by all teams.

We were told that the changes, due to be implemented in January 2024, would be communicated to members of the relevant teams as part of the communication plan. This would include full training for clinical and non-clinical staff to ensure that members of all teams with responsibility for cleaning were clear about their roles and responsibilities.

We reviewed housekeeper's cleaning records for September, October, and November 2023, the Cleaning Responsibility Framework, Cleaning Specification and Cleaning Record working draft for January 2024 implementation.

There was a good supply of cleaning materials available for staff to use. Staff followed infection control principles including the use of personal protective equipment (PPE). There was hand sanitising gel available in all areas we inspected, and we saw reception staff requesting that visitors use the gel before entering the wards. All staff adhered to the 'bare below the elbow' policy. Staff wore PPE and washed and gelled their hands regularly; hand gel was readily available throughout the building and posters displayed the five moments of hand hygiene.

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

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.

Patients could reach call bells and staff responded quickly when called. We saw that staff were always close by for patients and families which meant that patients didn't always find it necessary to use call bells but speak with staff directly while they were on the ward.

The design of the environment followed national guidance. The building was 2 storeys with offices, staff facilities and large facilities for meetings and training areas on the first floor. On the ground floor the hospice had capacity for 21 patients and at the time of our visit there were 16 patients on site. These beds consisted of 5 single rooms and 4 bays which had space for 4 beds which provided more space and privacy for patients.

Staff carried out daily safety checks of specialist equipment. Syringe pumps for the continuous administration and end of life medicines were kept on site, maintained and used in accordance with professional recommendations. We saw portable equipment had been safety tested and were within date.

The service had enough suitable equipment to help them to safely care for patients. The multidisciplinary team worked together to identify any equipment needed to provide care and treatment in the home. Staff disposed of clinical waste safely. There were sufficient clinical waste bins throughout the hospice.

End of life care

There was a mortuary on the inpatient unit for deceased patients waiting for transfer by the funeral directors. The area was spacious with a large bi-fold viewing area with soft lighting and sensitively presented. There was a garage attached, the internal door would not open until the external door was fully closed for privacy and dignity.

The first floor had a dedicated 'learning zone' for staff training which we saw was well used as there was training being delivered on the day of our inspection.

There were dedicated changing rooms for staff so that they were able to change out of uniform after each shift for it to be cleaned in time for their next shift.

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. Any unexpected deterioration was escalated for review to the medical staff.

The community nurses regularly contacted the inpatient unit to seek advice or ask for admission. One of the hospice consultants was able to perform some outreach visits to review the patients in their own homes. On the inpatient unit the consultants did twice weekly ward rounds and the patients were reviewed daily by the hospice doctors.

The clinical nurse specialist team reviewed deteriorating patients in the community with any unexpected deterioration referred to community palliative care consultants, appropriate health professionals or 999. Consultants carried out medical reviews daily, ward rounds were consultant led and occurred twice weekly.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff knew about and dealt with any specific risk issues. We reviewed 8 patient files and found staff had reviewed patients for risks such as falls, pressure ulcers, mouthcare and hydration. Staff we spoke with told us they knew the action to take for a patient who was assessed as deteriorating. The service had a deteriorating patient policy.

Staff knew about and dealt with any specific risk issues. We saw that staff monitored patient risks such as falls, pressure ulcer and mouth sores. Staff were aware of the importance of monitoring these risks. Audits were carried out on these risks and findings shared at team meetings and presented through governance with learning shared throughout the service. We saw the findings from relevant audits had been shared with staff.

The service had 24-hour access to mental health liaison and specialist mental health support from the local NHS Mental Health Trust.

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

Staff we spoke with knew how to refer patients with mental health needs to the local authority mental health team, they told us as soon as a patient exhibited any suicidal ideation or self-harming intention, the first action was to ensure the patient was never left alone.

End of life care

Staff shared key information to keep patients safe when handing over their care to others. We attended the team handover meetings and heard patient information being shared with other health providers, for example, GP services and other teams involved in patient care.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. Leaders at the service told us they used bank staff only who were familiar with the service.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Leaders were reviewing a range of data-based decision-making tools to ensure the appropriate amount of staffing and staffing numbers reflected need. Ward managers safe staffing was scrutinised at clinical governance meetings.

The service leads discussed The Safer Nursing Care Tool (SNCT) with NHS England and determined that this would not be suitable for their service needs, as it has not yet been validated within hospice care. Although they did not proceed with the use of the tool, they found it to be a useful exercise, as it allowed them to identify that both their senior sisters & consultants were aligned in their assessment of complexity.

They also considered other tools and reached out to other hospices to confirm the tools they used, however, there did not appear to be any consensus.

The nursing establishment was 21.5 whole time equivalent (WTE) in December 2023 and working to a nurse: patient ratio of 1:5. Royal College of Nursing (RCN) Guidance, Mandatory Nurse Staffing levels (2012) & NICE Safe Staffing for Nursing in Adult Inpatient Wards indicate that nurses should not have more than 8 patients during the day, therefore, the service were performing better than the required target.

In addition, they utilised Barthel to measure patient dependency and to support their decision making relating to staff mix. They developed a traffic light system, whereby if it was identified that they had high dependency, they would consider if additional staffing was required.

Nursing rotas were completed by the clinical rota coordinator. The rotas were planned at least 4 weeks in advance and checked by the senior sisters.

We were told that the staff were usually very accommodating and would swap shifts when needed to ensure the unit was covered.

The service had a bank of nurses and care assistants, which were used to cover shifts that were still vacant due to being unable to fill with permanent staff. The service also used an agency in the unlikely event that they were unable to cover.

The service had recruited 22 new staff to clinical roles over the previous 12 months and had no current vacancies.

End of life care

The hospice recorded sickness absence by using 'Lost Time Rate %' and average number of days sick per employee, per year. The most recent data provided by the service showed an average of 6.6% of working time lost over the previous 12 months against the average of 3.4% nationally recorded by The Chartered Institute of Personnel and Development (CIPD).

Early 2023 saw a spike in staff absences across the service with the clinical departments combined having the highest lost time rate. They undertook a policy review and effective from the 12th June 2023, made changes to incorporate welfare calls on employees' day 1 of absence, a human resources (HR) representative was not required at meetings under stages 1 and 2 of the policy and simplified the standards to enhance understanding by all. These had reduced rates from 8.5% to 4.9% at the time of the inspection.

The service had staff turnover rates of an average of 7.3% over the 12 months from January to December 2023, which included one quarter from April to June 2023 which had high turnover rate of 15%, at the time of the inspection it was 4% for October to December 2023. Over the 12 month period, the service had 19 leavers in their clinical departments. The review of reasons from exit interviews were new jobs, retirement, dismissal, personal reasons and studying.

Medical staffing

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

The service had enough medical staff to keep patients safe. All the consultants working for the service had substantive posts within the local NHS Trust. The service also employed trainee doctors and doctors with specialities in palliative care.

The medical staff matched the planned number. The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service planned the medical cover in advance each week.

The service did not use a locum agency, managers told us they would use bank staff to fill any gaps when required and tried to source the same staff wherever they could.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends. Out of hours there was a first on call rota of clinicians responsible for covering inpatient care. The first on call clinicians were supported by a combined rota of consultants in palliative medicine.

Consultants of Palliative Medicine were employed by a local hospital NHS trust. Due to this, they were not included in the hospice's employee data. They were supported by 4 permanent hospice doctors, 2 bank doctors and GP trainees. The service was a placement site for Year 4 medical students for 40 weeks of the year. Up to 3 medical students attended at a time, on a weekly basis. As well as making sure the students were able to cover the basics such as verification of death and completing death certificates, they also ensured they spend time talking to the patients, learning how to conduct an holistic assessment and the benefits of multi-disciplinary team (MDT) working. They also had 2 GP registrars on placement at the Hospice for 6 months at a time.

End of life care

The service ensured appropriate medical cover during the day by having on-site doctors 7 days a week and had 2 consultants in palliative medicine who covered the unit Monday to Friday. They had overall responsibility for the medical care of the patients, they had oversight and supported the team of doctors, they conducted 2 ward rounds per week and led the weekly MDT meeting and linked with other palliative care consultants in the area.

At the time of our inspection there was no consultant in palliative medicine in the community, 1 of the inpatient consultants carried out home visits if required and advised GPs and community teams, they also admitted to the inpatient unit if necessary.

Out of hours they had a doctor on call who could be accessed by inpatient unit staff for advice and support for inpatients, they attended the unit if required

There was also an electronic palliative care coordination system (EPACCS) in the local area which the doctors could access for information about patients who were in the community.

The service took admissions 24/7 and a doctor attended the hospice to admit patients out of hours. We were told of various situations when doctors had stayed longer than their shifts or come in from home in order to admit a patient to save them waiting.

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.

Patient notes were comprehensive and were mostly stored on an electronic information system, however some were yet to migrate to the new system and were paper based. Patient records we viewed were mostly comprehensive and up to date and demonstrated staff seeking consent from patients. All Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) documents were completed correctly. This documentation was used by the hospice to assess a patient's mental capacity to make decisions on a situation specific basis, for example, health or accommodation needs.

Although the electronic system was well used, the nursing notes remained in paper format. We raised this with the service leads during the inspection and were told they were in the process of becoming fully electronic to ensure seamless care records.

Records audits were carried out, which we reviewed and found compliance was consistent with what we saw on site during the inspection.

Records were stored securely either on the electronic system or in paper format that was only accessible for staff. Staff needed a secure log in to access patient records. Staff told us they kept passwords safe, and we observed they locked computers when they were not in use.

All the information needed to deliver patient care in a timely manner and to understand the care, medical and spiritual needs of patients was detailed in the patient care plan.

Medicines

The service used systems and processes to safely prescribe, administer and store medicines, however this was not always documented correctly. The service had pharmacist support from a local NHS trust.

End of life care

All medicines were requested from one supplier which the hospice had a service level agreement with, this meant there was a consistency in the delivery and fulfilment of medication requests. However, this contract was due to end and the service were in the process of securing a new provider. If medication was required outside of these times, staff could refer to the out of hours pharmacist.

At the time of the inspection, the service were considering alternative providers of medications and had identified the transition as a risk which would be monitored as part of their risk and governance process.

As part of the service's governance framework, we saw that medicines management was overseen by the service's medicines safety officer and scrutinised at board level where they discussed issues such as supply and costs.

The clinical team had a schedule of audits they completed which included fridge temperatures, missed dose audits, medication management and controlled drug storage. We saw fridge temperatures were checked daily and in line with national guidelines.

Staff stored and managed all medicines and prescribing documents safely. The hospice had appointed a controlled drugs accountable officer to be responsible for the monitoring and auditing of the management and use of controlled drugs. Controlled drugs were stored securely, and audits showed where they were compliant, follow up actions had been noted such as revising policies on the correct completion of controlled drug charts for staff reference and updating training materials with examples. The team were also involved in a pain management audit working group.

The pharmacist attended the consultant ward round and offered advice on medicine management to staff and patients. Pharmacy staff were responsible for checking medicines for new patients to the service and for checking any take home medicines when patients were discharged.

There was a prescription policy for the secure and safe use of prescriptions. Prescriptions that were not on the electronic system were stored in a lockable cabinet. There was also a policy for the disposal of medicines which were no longer required. These medicines were stored in a lockable cupboard until disposal could be arranged.

Staff followed systems and processes to prescribe and administer medicines safely. Daily checks were completed on any new prescriptions or dose changes. The pharmacy team were responsible for notifying staff of any medicine alerts such as drug recalls.

Staff completed medicines records accurately and kept them up to date. We reviewed 8 medicine administration charts and found staff had documented patients' allergies.

Medicines' charts were clear, in date, legible and prescribing was in line with current guidance and quality standards.

The clinical team completed various medicines audits. We reviewed audits for the previous 3 months concerning antibiotic usage, self-administration of medicines, missed doses, and the management of controlled drugs and found the hospice was compliant in most areas and where non compliance was found, they had improvement projects to address this. One example of this was a spike in medication documentation related incidents reported.

The measures that had been put in place following the medications incidents included staff identified to work alongside the educator to develop an in-house training package.

End of life care

We heard from many staff and leads about the work that they had done around the prevention of such incidents and saw no issues of this nature during the inspection.

The pharmacy team provided a comprehensive service to the patients and hospice staff.

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 raised concerns and reported incidents and near misses in line with the service's policy.

Staff used an electronic system to report and review incidents. All incidents were investigated and reviewed for learning purposes.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw evidence that duty of candour had been completed and patients had been made aware of investigations and outcomes; for example, we saw an investigation following an incident where the family had been informed of the incident and the findings.

Staff received feedback from investigation of incidents, both internal and external to the service. Following investigations and feedback from patient safety group meetings, posters and newsletters were developed for staff areas to give staff an overview of incidents, outcomes and any updated learning or procedures.

There was evidence changes had been made as a result of feedback. We saw evidence of discussions following incidents and the changes to be made to policies or procedures to improve patient safety. For example, we saw evidence of an investigation following an incident involving medicines management. The hospice had completed a thorough investigation, made recommendations for changes following the investigation and put an action plan in place with a timeline for completion. We saw evidence this incident had been discussed at the patient safety meeting.

We reviewed incidents data from April 2022 to April 2023 which showed the service had no incidents of severe harm and 1 moderate from a total of 159 incidents reported both internally and externally. All incidents related to either inherited pressure ulcer, acquired pressure ulcer or medication. We also reviewed data from April 2023 to December 2023 which showed 107 incidents reported, all of which were graded as low harm or below. Medication remained within the themes, however documentation errors had reduced, therefore we heard how the service were focusing their action plans towards an entire review of medication processes.

Managers debriefed and supported staff after any serious incident. Evidence we saw in investigation reports detailed measures put in place to communicate and support staff after incidents.

End of life care

Is the service effective?

Good 

Our rating of effective went down. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients 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. Staff holistically assessed people's physical, mental health and social needs, and delivered care and treatment in line with legislation, standards and evidence-based guidance.

The hospice followed up to date guidance to ensure patients received effective and high-quality care. These included National Institute for Health and Care Excellence (NICE) guidance this included but was not limited to; Care of dying adults in last days of life, Controlled drugs: safe use and management and Leadership Alliance for the Care of Dying People: One chance to get it right. The service also used NICE guidance for audits and clinical reviews.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At the handover meetings and ward rounds we attended, we saw staff refer to the psychological and emotional needs of patients, their relatives and carers.

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 had enough to eat and drink, particularly those with specialist nutrition and hydration needs.

Each patient had a detailed care plan with specific details on dietary, feeding and hydration regimes which was updated at every admission to the hospice. A food and drink plan was attached to nutritional part of the care plan on the database.

Each patient's bed number and any nutritional or hydration needs were recorded on a whiteboard, which also included any food likes or dislikes, allergies and digestion difficulties. Drinking water was readily available to staff, patients and their visitors.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Records we saw detailed patients' fluid intake and any support needs for eating. Patients could also be referred to a speech and language therapists (SALT) who worked with patients to assess any speech or language difficulties, communication or eating and drinking difficulties. The therapist could then make recommendations.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition or obesity. It also included management guidelines, which could be used to develop a care plan. We saw a Hospice Nutritional Assessment Tool

End of life care

being used. We saw as part of the nurses intentional rounding, they regularly offered patients drinks and asked if they wanted anything to eat. Intentional rounding (IR) is the structured process whereby nurses in hospitals carry out regular checks, usually hourly, with patients using a standardised protocol to address issues of positioning, pain, personal needs and placement of items.

Staff showed a clear understanding of the difficulties their patient group could have with nutritional intake where often their appetite was poor or oral intake could be difficult due to swallowing problems. There was provision for patients who did not want regular meals or who did not want to eat at set times. Staff told us they always kept a selection of sandwiches, soups and cereals for patients. Staff, patients and families all told us that they would provide whatever food the patient wanted and often made meals or snacks separately and to their requirements at that time.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used pain tools appropriately, the Abbey pain scale was readily available if needed. The Abbey pain scale is a tool designed to assist in the assessment of pain in patients who are unable to articulate their needs for example if they had any communication issues. Staff recorded information around patients' pain in a pain care plan when needed. The morning ward round was attended by the consultant and pharmacist and other clinicians. We saw pain and symptom relief was discussed with each patient and recommendations made where changes were needed. Patients were reassured about pain control and the plan for management of pain moving forwards.

Patients received pain relief soon after requesting it. Patients and their families told us nursing staff administered medications on time and reacted quickly to requests for pain relief or management of other conditions. They told us nursing staff checked patients pain levels and asked if they needed further medication.

Staff prescribed, administered and recorded pain relief. The medicine and drug charts we reviewed were all completed and dated and signed correctly. Following review of incidents within the service, we saw times when there had been error in medication administration. However, staff we spoke with understood the importance of pain management and evidence we in records on site showed staff prescribing the correct medicines. The service had improved the assessment of pain for patients using recognised and validated assessment tools throughout a patient's admission. They had developed a pain assessment booklet to be kept at the patients' bedside which nurses completed pre and post analgesia.

We saw all medications for pain were documented fully and accurately and patients gave positive feedback.

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 been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. The hospice took part in local and national audits and benchmarked itself against other services in the area and nationally. They took part in the Executive Clinical Leads in Hospice and Palliative Care (ECLiHP) care audits. Benchmarking compared areas such as discharges, bed occupancy, pressure ulcers and medication errors.

End of life care

In February 2023, the service participated in the Hospice UK National Audit of Care at the End of Life (NACEL). The audit looked at case notes of 620 patients who had died in the 69 hospices. Dove House Hospice audited 10 sets of case notes.

The aim of this case note review was to pilot the use of the revised case note review tool and to review and understand the levels of care that patients and those closest to them experience in the last admission to a hospice before death. Overall feedback was produced in the Hospice UK National Audit of Care at the End-of-Life report, the service did not receive individual feedback for Dove House Hospice.

Hospice staff who completed the audit commented that they felt the service's completion of documentation around conversations at the end of life could have been better, this was also demonstrated by the national feedback. The service completed some further training and refreshers on the importance of documentation, which resulted in improved results.

The Integrated Palliative Care Outcome Scale (IPOS) tool was used consistently by the hospice doctors on admission, throughout a patient's stay and on discharge/death. The data extracted from this showed how well the hospice was performing in managing symptoms, it also helped to highlight areas where they may need to improve.

At the time of our inspection, the service were involved in developing a palliative care outcomes registry. The purpose of this work is to create and implement a registry based on patient-centred outcomes data.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We saw that the service had a comprehensive audit programme which included mouth care, pressure ulcers, controlled drugs administration time, respiratory and cough hygiene and person-centred care. The audit programme ran across every 12 months, we saw many audits had been completed, some in progress but none were overdue.

The hospice had audited the number of patient falls for the period from April 2023 to December 2023.. Following the audit, the learning was shared with all staff, who were involved in the action plan, which they monitored for the impact on patient safety.

Data from the last 6 months showed that between 96% and 100% of patients had their preferred place of death recorded and between 40% and 70% achieved this. In the instances where this had not been achieved, results showed several different reasons, for example if the patient had been too unwell to travel or if the patient had been discharged home or to another care setting to die.

In addition to the service's internal scrutiny, they take part in the regional Retrospective Death Quality Audit. We saw correspondence showing the service had been commended following a review of one of their cases. They were praised for 'high level sensitive care and support in this emotive case'. They were said to have provided 'excellent example of multi-professional working'.

Performance and outcome information was collected and collated by the clinical information coordinator. The key performance indicators (KPIs) included information regarding advanced care planning such as preferred place of care/death. The service also completed the ReSPECT form which records a patient's wishes and preferences including resuscitation status. The

ReSPECT form could be accessed by any service provider, this ensures that everyone involved in a patient's care had the most up to date plan of care.

End of life care

The KPIs also included the patient safety thermometer, this was done as a snapshot once a month for Hull patients. The safety thermometer reported on pressure ulcers, falls, and catheter acquired urinary tract infections.

Outcomes for patients were positive, consistent and met expectations, such as national standards.

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. The service ensured staff completed training appropriate to their role, clinical staff also had an internal clinical skills training programme which included syringe driver training, cardiopulmonary resuscitation and manual handling. The service gave all staff an induction suitable to their role. Staff we spoke to said they felt that the training they had for their role was appropriate and that the service also did extra training when needed such as training on different end of life needs of diverse cultures.

Managers gave all new staff a full induction tailored to their role before they started work. All new staff were provided with the service vision and goals, useful information and a checklist for managers to complete. Volunteers to the service were also given a full induction and a training pack.

Staff told us that they were encouraged to develop and enhance their skills and knowledge and were given time to do this. There was a range of additional skills training that was available and had been undertaken by most staff such as care of gastrostomy tubes, non-invasive ventilation (NIV) and cough assist, stoma care, catheterisation, verification of death and tracheostomy care.

The service also provided weekly internal doctors training sessions which had various topics, for example, difficult conversations, ethics, malignant bowel obstruction and nausea/vomiting, capacity assessment and opioid toxicity.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff we spoke to said they had a yearly appraisal, there was also clinical supervision for clinical staff. Staff said they had opportunities for learning and were able to develop in their roles such as becoming leads for specific areas of interest or to support other staff. Staff said they accessed clinical supervision and found this helped them with learning and support. The counselling team were receiving supervision which was suitable for their roles.

The clinical educators supported the learning and development needs of staff. The hospice had an education team which was supported and encouraged to develop continuously.

Multidisciplinary working

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

We reviewed minutes from meetings and saw staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw good examples of multidisciplinary team working, for example during our time on the unit we observed all staff working together for the best patient experience. Social workers were based on site and

End of life care

were fully integrated for joined up care and treatment and to ensure delays were minimal in meeting the needs of patients. Ward rounds were attended by the medical team, ward nurses, occupational therapist, physiotherapist and pharmacy team. The daily huddles were attended by relevant specialists and there were good conversations around patient care and needs.

Staff worked across health care disciplines and with other agencies when required to care for patients. Meetings related to locations of patients and their preferred place of death were attended by the local providers where bed allocation and availability across the region was discussed. There was a good exchange of information and team working.

Where appropriate, staff shared information with other service providers such as GP surgeries, care homes and mental health teams. Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff we spoke to knew how to access the local mental health team and other providers for support such as substance misuse teams.

Seven-day services

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

Patients could access the service 7 days a week, 24 hours a day if needed. Specialist nursing and medical support was available 7 days a week and patients were reviewed daily. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, 7 days a week.

When on call, staff had full facilities to remain on site in a furnished flat in order for them to be immediately accessible.

Housekeeping staff were on site 7 days a week. Physiotherapy, occupational therapy and complementary therapy services were available to patients in the hospice from Monday to Friday.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. Patients had access to personal health budgets (PHB's) which they could use for a range of things including purchasing equipment and had helped prevent delays in getting people home. This supported patients to remain in their own homes and achieve their preferred place of death.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff showed a clear understanding of the difficulties patients accessing hospice services could have with nutrition and maintaining a healthy diet.

The service display information for patients on eating well, self-care and there was a wellbeing service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff helped patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. Staff 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 we spoke with as part of our inspection, demonstrated knowledge and understanding of the Mental Capacity Act 2005 (MCA)

End of life care

and Deprivation of Liberty Safeguards (DoLS), and the procedures and documentation used by the hospice to assess a patient's capacity. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The legislation states that before a mental capacity assessment can be undertaken, there must be 'Reasonable belief' the person lacks capacity.

The service undertook an audit of mental capacity assessments in June 2023 in which 20 mental capacity assessments were audited, none were found to have been undertaken on patients with no 'Reasonable belief' they lacked capacity.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff we spoke with understood the importance of consent when delivering care and treatment to patients. We observed staff seeking consent from patients prior to examination, observations, and delivery of care. In most cases this was implied consent and not documented. However, when an intervention was required, formal written consent was sought. Staff clearly recorded consent in the patients' records.

Conversations about care often included family members where their views were also gathered. Staff gained additional consent from patients and their relatives to allow them to document this consent on the patient record.

We looked at 6 ReSPECT forms during our inspection, which included a section regarding the patient's wishes regarding resuscitation. All were completed correctly and where appropriate were discussed with the patient.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Data showed that 100% of eligible staff had undergone training on undertaking mental capacity assessments.

Is the service caring?

Outstanding



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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

We observed staff interacting with patients in a way that enabled them time to ask questions, gain clarity and an understanding of treatment and care. Patients said staff were very kind and caring and treated them with dignity and respect. Patients told us that staff always had time to have open and honest conversations about their prognosis even when these conversations were difficult to have.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. For example, staff were able to accommodate appointments around patient's work schedules, and religious activities such as prayer times for those of Islamic faith. Staff told us they were able to seek support if they were unsure of the cultural needs of any patient.

End of life care

All of the patients and their families we spoke to during our inspection gave overwhelmingly positive feedback about the care they had received. Patients told us of the 'unbelievable' and 'above and beyond' care they had received. Staff organised special events such as 'Light Up a Life' which was celebrated annually when families and friends of the hospice gathered to reflect and have ongoing support. The service also had regular events weekly and monthly for the community, patients, relatives and friends which all had significant numbers in attendance.

The service had 2 self contained flats on the first floor where families could stay and be close to their relative. The service also had agreements locally for patients and families to take short breaks to the hospice caravan nearby.

We saw how compassionate and caring the staff were to patients and their families. Family members told us of the support and advice they had received and how responsive the team were to their concerns. Nursing staff took time to offer psychological support to patients and their families as well as medication advice.

We saw patients having visits from their pets during our onsite inspection. We also heard of numerous stories when staff had arranged for patients' horses or ponies to come to the hospice and spend time with them. Patients and families had overwhelming praise for the lengths that the service and all staff went to ensure patients had their wishes realised. We were also told that a beer lollipop was made for a patient who was nil-by-mouth but fancied a pint.

Staff followed policy to keep patient care and treatment confidential.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. All staff demonstrated a deep understanding of the emotional impact living with a life-limiting condition had on patients and their relatives and consistently took account of this when providing care and treatment. During our inspection we were told by staff, emotional support came in different forms depending on what was required by the patient and those close to them. The services at the hospice worked together as a multidisciplinary team to support the emotional needs of the patient and their families.

We saw staff were positive and attentive to the needs of patients at the hospice. We observed staff providing kind, thoughtful, supportive, and empathetic care, support, and advice. Relatives also commented on how supportive the staff were. 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 emphasised that family or a caregiver's emotional needs were equally important to that of a patient. The service put both patients and their family at the centre of their care and made sure people received the support they needed. Staff promoted support for patients as well as the needs of family or caregivers. Activities were available for both patients and their families such. The service had a number of social activity groups which had been set up to help anyone connected with the hospice who may be feeling lonely or isolated and would benefit from support and company of other patients through a shared interest or hobby.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff we spoke to told us how helpful this training was and there was access to emotional support for staff out of hours for if they needed it.

End of life care

The hospice had a pre and post bereavement service provided by their on-site team, there was no time limit on how long after a bereavement people could access the service. Patients also had access to palliative care social workers who specialised in working with adults who are at the end of their life. The palliative care social workers could complete assessments for care and support for patients and their families in areas such as housing, benefit advice and will writing. They brought social care expertise and perspective to situations to ensure that people get the support they need.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff were fully committed to working in partnership with patients, involving them in decision making processes about care and treatment. Staff made sure patients and those close to them understood their care and treatment and supported patients to make advance decisions about their care including preferred place of death and ceiling levels of treatment. The ceiling level of treatment was the “upper limit” of treatment for a patient in the eventuality of the patient becoming acutely unwell or deteriorating from a chronic illness.

The relatives and loved ones of patients actively sought out inspectors to let them know how wonderful and caring the staff were during our inspection. One comment an inspector received was “the staff are incredible! They cannot do enough for you”.

We saw hundred of overwhelmingly positive comments gathered on the service’s compliments database such as;

“At Dove House, you are not just treated like a patient, you are looked after as a whole family and we were included every step of the way, every decision was made with us.”

“We felt like we were on our own until a nurse referred us to the hospice and now, they are the first

people I know we can call on to help us. Without Dove House, we would have been lost. We can breathe a bit easier knowing Dove House is there for us.”

“Dove House give 100% in everything they do and if there was more to give, they’d give it.”

We also heard the team helped a Ukranian refugee make plans for after their loved one’s death and ensure they were able to follow their traditions.

Relatives of patients we spoke with felt they and their loved ones had received the information they needed to understand about and make informed decisions about their care. Information was explained gently and with sensitivity, questions were never ignored or remained unanswered. We were told they were kept fully informed, staff had time to answer questions and would answer in a way they could understand.

Staff routinely discussed with patients any concerns they might have about the progression of end of life including preferred place of care or death, concerns about medications and side effects, emotional support for family members or friends and financial concerns.

End of life care

The service had 58 Family and Friends tests returned over the last 12 months, of them 57 answered 'extremely likely' and 1 'neutral'. They receive a large amount of feedback in the form of letters and cards which were scan onto their compliments database. The service recognised that considering the numbers of patients they care for, the figure for family and friends test returns was low and were looking at ways to increase and encourage feedback from service users formally.

The community engagement and service user lead post was vacant for 6 months, however this had recently been filled and the service said this was integral to service user feedback.

A meeting was planned for January 2024 to discuss ways of increasing feedback for the Family and Friends Test and other forms of service user feedback. An initial meeting regarding service user feedback had resulted in a plan, which was due to be discussed at the January meeting.

Is the service 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. The service worked well with other service providers to provide the best care for patients. The service was flexible and planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised services, so they met the needs of the local population. There were innovative approaches to providing integrated person-centred pathways of care which involved other service providers particularly for people with complex and multiple needs. The hospice inpatient unit provided 24-hour care for specialist palliative care patients. Specialist admissions could be for symptom control or end of life care.

The service did not run a Community Hospice Care Programme (CHCP), however this was something which they planned to provide in the future. In the meantime, we were told that their inpatient consultants and nurses saw patients in their own home if required and supported patients and families to access the relevant services when they were struggling. The unit also provided an outpatient service to support some community care and provide some daytime respite care.

The service provided a one point of contact for patients, their families, and other professionals. Patients and their families could access holistic hospice services, including medication advice, therapies, social work teams and pre-bereavement and bereavement support, including child bereavement services.

The hospice had set up various community initiatives to help engage diverse communities, and develop relationships with key leaders, who may not normally access hospice services for reasons of culture or accessibility. They had held events to reach out to other communities and gain a better understanding of their end-of-life belief systems and ways to support them to access services. For example, the team had organised events for the travelling community to discuss supporting end of life and accessing other services. They had worked hard to mitigate some of the stigma associated with hospice care and tried to educate around some of the misconceptions about hospice services. For example, relatives visiting family members was not restricted and culturally appropriate meals were available.

End of life care

The staff told us they aimed to be able to provide services for all and to make a difference to the community. They had 'Welcome Wednesdays' monthly for people from the community to gather and activities were provided. Every Friday the hospice held a social isolation group which was open to anyone in the community.

The service also had a community café on site where we saw groups having Christmas lunch on the day of our inspection.

Facilities and premises were appropriate for the services being delivered. The service had spacious rooms, areas for group support meetings and a coffee area for spending time with family and friends plus quiet rooms. There was a large garden area and ample free onsite parking.

There was a large reception area, a large space where patients groups were held, which was light and welcoming. The hospice had an area with seating for patients and families to buy refreshments, there were also quiet areas with soft, homely furnishings and rooms for families and loved ones to use. There was a dining room and separate café for the community, a small chapel and areas to purchase items.

Outside the ward area there was a 'Smile Room', which was for visiting children to engage in activities, watch television, play games, read or spend time quietly with lots of soft toys. This room had been decorated colourfully and appeared welcoming and exciting for children to have their own area.

There was an outside garden area with benches and a large shed which had been converted for patient activities. There was a large pond with coy carp and other wildlife, which was bordered by glass panels and seating for patients and visitors to spend time outdoors. Patient rooms were clean and clutter free, large patio doors led out into the garden and were wide enough for beds to be pushed through. The flats on the first floor had balconies which also overlooked the gardens. Families we spoke to told use the outside area was used frequently and was a nice place for patients to be able to go and sit. All the bathrooms and shower rooms were clean, and the furnishing were in good condition. Bathrooms had signs to show they had been cleaned and were ready for use. One room had a specialist designed bath for patients to use which had a variety of functions including lowering and jacuzzi.

Managers monitored and took action to minimise missed appointments. Managers ensured patients who did not attend appointments were contacted.

Meeting people's individual needs

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

The hospice had a pre, post and child bereavement service provided by the on-site team. The bereavement service offered support and counselling to family and friends of patients. There was no time limit on how long after a bereavement people could access the service. Patients also had access to palliative care social workers on site who specialised in working with adults who were at the end of their life. There was a counselling service available for patients to access for support.

The service had a faith room with facilities for all faiths and none to use, the room had a book of remembrance for friends and families, which was open at the day's date and showed all that had passed away on that date over many years, including staff and families.

End of life care

The service also offered complementary therapies to patients and carers, and this area was clean and appropriately furnished.

The service had suitable facilities to meet the needs of patients' families. The hospice had separate accommodation where service users could stay with their family members. The hospice had a catering team onsite and each morning patients were asked what they would like to eat and if there were any special dietary needs. There were several different aspects to the food served by the kitchen. For example, culturally appropriate, vegetarian, vegan and specific diets concerned with food allergies. Catering staff told us they were passionate about providing the best possible nutrition to their patients. We attended the lunchtime meal service, and saw that meals were served at different stages and not all at once. This meant that food did not arrive with 3 courses on one tray but when each course had been finished and when the patient was ready for the next course.

There was an onsite café where food was provided by the same catering team, families could eat there, as could anyone from the community. For those who stayed overnight there were hot drinks, and a sandwich or toast.

Patients and their family members told us the food and the catering staff were of a high standard and staff took time to make meals times as pleasurable as possible. One patient told us when they were admitted to the hospice they had not eaten properly recently as they had very little appetite, however, the food was so delicious and so well presented at the hospice they had been eating very well.

Patients had access to personal health budgets (PHB's), which they could use for a range of things including purchasing equipment and had helped prevent delays in getting people home. This supported patients to remain in their own homes and achieve their preferred place of death.

Staff made sure patients living with mental health problems received the necessary care to meet all their needs. Staff could make referrals to the local mental health teams for patients in need of support and there were other support services available. The service had a clear referral process for patients in need of support for mental health problems and staff were able to explain the process to us.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. The hospice had a dementia lead who was able to give staff advice and information for patients with communication needs. The service had developed an education programme of early interventions for people living with dementia as they had recognised this patient group often attended in crisis. Staff told us most patients living with dementia or with learning disabilities were seen in their preferred setting wherever possible, however they had a designated area for patients who required specific sensory adjustments.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The hospice website had been adapted to enable users to select a language which automatically changed the entire website into that preferred language.

Staff were able to demonstrate how translation services could be accessed when needed. If the need for an interpreter was recorded at the point of referral these would be pre-booked prior to appointments.

End of life care

Staff told us of an occasion where they were caring for a patient from Nigeria. A member of the team provided support to other staff to help them to understand the patient's needs, cultural beliefs and preferences, and they cooked traditional Nigerian food for them to eat whilst at the hospice. The service also researched and printed out information to support this patient's needs. A member of the Family Support Team also supported both the patient and the family, and they liaised with the family from Nigeria through video calls to ensure they were included where possible.

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.

The hospice had a clear referral and admission criteria and process, and these were processed in a timely manner. Staff triaged the referrals and were able to prioritise patients in need of urgent care and request support from nurse specialists when needed.

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

The service reported their waiting times monthly for the inpatient unit. The maximum waiting time over the last 12 months was 5 days. If beds were full, they had a waiting list and patients were responded to regarding clinical need not length of wait.

Waiting times were influenced by the number of beds available, patient gender, clinical need and staffing levels on the inpatient unit. There had been a number of new clinical staff in post since summer 2023 which had enabled them to open more beds and reduce waiting times.

During the referral process, patient needs and level of care were recorded. We saw and were told that patients with the most urgent care needs were prioritised and their treatment needs were discussed. New admissions and bed availability was also discussed at daily meetings.

The hospice is a member of the Hull Champions Programme, which offers the opportunity for them to network, raise awareness and promote their services with individuals, communities, and organisations from underrepresented groups in the local area, through monthly meetings.

Managers and staff started planning each patient's care as early as possible. They worked with patients and their families and linked in with the on-site social work team to arrange any home care packages and to ensure a safe discharge home after respite or if the patient preferred to return home. Discharge planning meetings were held with the patient, family member and the multidisciplinary team.

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. The service displayed information on how to make a complaint and patients were given advice on the process when needed.

End of life care

Staff understood the policy on complaints and knew how to handle them. Staff were able to explain the complaints process to us and the procedure for handling complaints. Complaints were recorded on the services electronic recording system.

A copy of the service complaints procedure was available in the reception area and the website for the hospice details ways of contacting the service and the complaints procedure.

Managers investigated complaints and identified themes. Minutes from governance meetings showed that complaints were discussed at this level and investigations undertaken.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service had received 2 formal complaints in the past 12 months, both were fully investigated, and formal written responses provided. Learning was identified and action plans developed which were shared with the clinical teams.

Is the service well-led?

Good 

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

Leadership

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

The service had a clear management structure and staff we spoke to said the senior leadership team were visible and accessible. Staff told us they knew who to go to with concerns and they were able to raise issues with confidence.

Leaders had the skills, knowledge, experience, and integrity they needed to provide effective leadership. They worked with other organisations to address any issues and manage their priorities. The leaders of the service had a clear understanding of the priorities for the service and the challenges they faced.

The service was led by the executive management team supported by the board of trustees. The executive team included a chief executive officer (CEO) and the director of finance and support services. The service also had consultants in palliative medicine, a director of clinical services, a director of people and development and director of business and income development who was also the deputy CEO.

The governing board of trustees met 8 times a year (6 board meetings plus 2 away days). All trustees held the post in a voluntary capacity and had varying skills and expertise.

All staff we spoke with gave overwhelmingly positive feedback on the leadership team, including trustees. All were said to be visible and showed keen interest in how staff were feeling as well as how patients and their families were being cared for.

End of life care

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.

Their mission was to 'preserve the dignity of our patients and those who care about them, respecting their individuality, acting with honesty and integrity at all times. Continually strive to review and improve the services we offer to ensure that they meet the changing needs of the people of Hull & The East Riding of Yorkshire. Offer to share with others the knowledge and skills that are vested in our staff.'

The hospice had a clear 5 year strategy of what it wanted to achieve and the actions it needed to take to achieve its vision of 'Every adult within our community with a life limiting illness has the best quality of life possible, with easy access to high quality palliative care in the setting of their choosing. The hospice had a clear set of values to be 'passionate, positive and professional'.

The 5 year strategy was developed during 2022/23. The service reviewed the previous strategy and analysed where the hospice currently was to create the new strategy. This strategy will be implemented in 2023/24 and will guide decision making developments for the next 5 years, including plans for community care.

It was developed through a robust programme of stakeholder engagement and the support of professional analysts, which has provided a platform to help people shape what Dove House should look like in the future. This involved talking to all stakeholders; from patients and families to those that commissioned services, staff and volunteers and the community that supports them, health care professionals and the wider healthcare sector. The 5 year strategic plan was produced by the trustees and executive leadership team but guided and directed by the narrative in their stakeholder feedback.

Culture

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

Staff we spoke to said they felt supported and valued and were proud to work for the service. Staff told us they had been given opportunities to develop in their roles and felt they could give feedback to management without fear.

The service had a freedom to speak up guardian who staff were comfortable to contact if they had any concerns or felt they needed support. The service had counsellors on site and staff could talk to any of the team after any incident or situation where they felt they needed support whether work related or not. Staff could access clinical supervision and peer support to discuss patient cases and share learning. Staff could also use the holistic therapies provided by the service.

The hospice had staff 'Shout out' boards to celebrate the work staff did collectively and individually. Staff could place post-it notes on the board, which we saw during our inspection.

Staff we spoke to told us that all teams worked well together and tried to find solutions to help each other with workloads and to improve outcomes for patients.

End of life care

Staff had yearly appraisals which included the service values and vision and some objectives for staff to meet were developed around these and around their career development and learning needs.

All staff we spoke with during the inspection said they felt valued and were proud to work there. Many staff had worked at the unit for 30 years or more and had joined as newly qualified nurses. One member of staff we spoke with commented 'this is my forever job'. All staff worked well together and said they looked after one another including the leadership team, nobody felt inferior or superior to anyone and they were all part of one machine.

Volunteers we spoke with told us of their enthusiasm to be a part of the team and were always treated the same as paid staff and looked after in the same way.

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.

Structures, processes, and policies were in place to support the delivery of good quality services and the hospice strategy. The hospice had a governance lead and various groups that fed into the board.

Clinical focus meetings were held once a month with standing items on the agenda which included clinical incidents, falls, infection control, health and safety, audit and patient and community engagement. Any member of clinical services staff were welcome to attend this meeting; the Chairman of the Governing Board of Trustees also attended and a clinical focus newsletter was circulated for all staff to read.

Incident reports were shared with the senior sisters and head of nursing therapies and quality to follow up. Incidents were then discussed at the clinical focus meeting and reported to the Board.

The service also had a weekly clinical management team meeting, this was attended by all clinical heads of department.

A Medicine Management Safety Group was chaired by the medicines lead for the hospice and reviewed any medicine associated incidents, audit and investigation outcomes and highlighted any learning or training needs.

The service had a Quality Governance Committee and held meetings quarterly. In attendance at these meetings were trustees for the hospice, chief executive officer, directors of clinical services, head of governance and other key members of staff. Standard agenda items for the meeting covered areas such as but not limited to; future planning including seasonal pressure, serious incidents, performance data and operational risks. Minutes we saw from the meeting detailed actions to be taken and responsibilities for these actions.

Meetings were held to learn from deaths within the service and the wider integrated care system. A sample of deaths that occurred was discussed, and any learning shared. The meeting reviewed preferred place of care and death for patients as well as any hospital admissions that could have been avoided.

The service had a programme of clinical and internal audits to check quality and systems to identify where staff should be taking action. There was an audit calendar and an action plan tracker. The service benchmarked themselves against other hospices and submitted data for commissioning.

End of life care

We saw service level agreements were in place and leaders attended contract group meetings; the hospice provided commissioners with required information.

The hospice had a people team who oversaw the human resources processes. During our inspection we reviewed 5 staff files. These files were all correctly completed and had the relevant employment documentation.

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 a quality assurance process for the reporting of incidents. The governance team were notified of all incidents via an electronic incident risk management system. The governance team reviewed all incidents and identified actions to be completed. Incidents were rated according to level of harm and escalated accordingly for investigation. We could see from the log that the incident description and actions taken had been detailed.

The service had a risk register which reflected current risks within the service. Risks included but were not limited to funding. All risks had dedicated owners, risk and effect, control measures and risk ratings from red to green.

We saw evidence the risk register was reviewed and updated at the monthly management meeting. At this meeting, risks were identified and discussed, and a plan put in place to eliminate or reduce them. The risk register for the service was a standing agenda item.

The service had a range of risks, their highest rated included impact of national living wage, dependency on internal funders and the local hospital trust pharmacy ceasing to supply medications to the hospice. This was added to the risk register in November 2023 and had mitigations in place such as, regular meetings with the trust chief pharmacist.

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.

Staff recorded information via an electronic incident risk management system, and this was reported in the quarterly report. Managers graded the incidents and investigated each incident individually to identify any learning.

Staff were able to access computers and the hospice intranet and shared drives. Computers were password protected and staff locked them when they were not in use. Staff working in the community were also able to access systems for seamless care.

The hospice submitted data to external organisations as required.

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.

End of life care

The hospice worked in partnership with other services to ensure they effectively met peoples' needs. For example, they worked with the local NHS trusts, other hospices and palliative care teams as could be evidence their shared learning from experiences and training and development across the region and with the Hospices Collaboration Group.

The hospice gathered and acted upon people's views and experiences to shape and improve services and culture including people in different equality groups. For example, the hospice had also set up various community initiatives to help engage diverse communities, develop relationships with key leaders.

Managers used feedback from people who used services to inform improvements and learning. Complaints were discussed in staff meetings and patient stories and surveys were discussed in different forums.

Arrangements were in place to ensure staff could raise concerns safely; there were whistleblowing and disciplinary policies in place.

Managers sought and acted upon the views of staff in the service. Staff gave feedback through the staff survey; we saw the results from the last undertaken in January 2023, 139 staff had responded to the survey and the service scored overwhelmingly positive on staff feeling motivated and proud to work for the service as did feeling supported and valued, leadership and organisation. There were 87% of staff said they worked and lived the organisations values.

The hospice engaged with the community as well as service users and their families and friends. They had Dove House Carers Group, Dove House Bereavement Café – Welcome Wednesdays, Living Well Group and Friday Friends among others.

In December 2023 with the support of a local sponsor, the service welcomed over 200 volunteers for their first appreciation event since the pandemic. The service leads told us that they are always keen to show their appreciation and also provided all staff with 2 £50 vouchers each to support them over the winter period.

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.

The service was taking part in a Chelsea II trial with a small group of consenting patients who met the criteria. The trial assessed whether giving patients in the last days of life fluids via a drip (clinically assisted hydration) is effective at preventing them from developing delirium. The results of this trial were not available at the time of our inspection and is ongoing.

The service monitored patient outcomes for preferred place of death and learned from instances where this had not been achieved.

The hospice had taken part in the National Care at the End-of-Life Case Note review which hospices across the region had submitted case notes for auditing and feedback, this was good practice as it allowed an external organisation to review and give feedback.

The service took part in an implemented audits both internally and by external agencies. Areas covered by these audits were pressure ulcers, slips trips and falls, medication errors and discharges. The service general performed well in comparison to other services.

End of life care

The hospice personal health budget team supported patients across Hull with support ranging from household chores, to providing beds and linen so people could die at home in comfort and with dignity surrounded by their loved ones. The hospice had undertaken presentations and shared how to refer patients for the government initiative with many external professional teams.

A hospice consultant in palliative medicine, 4 hospice doctors and 2 rotational GP registrars, won the 'Team Excellence Award' for teaching in 2023.

The hospice was awarded 2 stars for the 2020 Best Companies to work for in the UK. This is classed as achieving 'outstanding' levels of employee engagement in the 2020 'Best Companies' awards.

The National Improvement Academy recently awarded the service certificates for embedding safety huddles 5 days a week and for achieving 60 days without a fall.

In July 2023, the service started a 6 month pilot period of a consultant-led hospice outreach clinic.

This was developed in response to currently two whole time equivalent vacancies for palliative medicine consultant positions in the community and although they had been offering outpatient assessments at the hospice, many patients who required specialist palliative medicine input were too unwell to attend an outpatient clinic.

The hospice outreach clinic service was provided by consultant sessions once a week by 1 consultant and 3 times a week by another when capacity allowed. In order to ensure that this was a pro-active service, the consultants linked in with the local providers and had referral and handover meetings each morning so that any patients requiring input could be identified and seen as soon as needed. Since commencing this service in July, they had provided 59 home visits.

This service had further strengthened the relationship between the hospice and the community teams and the service hoped to be able to continue this and develop it further in the future.