

Leicestershire & Rutland Organisation for the Relief
of Suffering Limited

LOROS The Leicestershire & Rutland Hospice

Inspection report

Groby Road
Leicester
LE3 9QE
Tel: 01162313771
www.loros.co.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

Overall summary

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

- Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients whose condition was deteriorating or were in their last days or hours of their life. The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. The service used systems and processes to safely prescribe, administer, record and store medicines. The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. They followed national guidance to gain patients' consent and apply the mental capacity act correctly.
- People were truly respected and valued as individuals and empowered as partners in their care, practically and emotionally.
- 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.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced and were proactive, embracing change to promote better services. Leaders operated excellent governance processes, and demonstrated commitment to best practice, performance and risk management systems and processes. They identified and escalated relevant risks and issues and identified actions to reduce their impact effectively and in a timely manner. All staff were committed to continually learning and improving services. Staff were actively participating in research and improvement projects.

Summary of findings

Our judgements about each of the main services

Service

Hospice services for adults

Rating

Good



Summary of each main service

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

See the summary above for details.

Summary of findings

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Summary of this inspection

Background to LOROS The Leicestershire & Rutland Hospice

LOROS is a charity whose aim is to enhance the quality of life of patients with cancer, progressive neurological conditions and end-stage organ failure for whom curative treatment is no longer possible. Patients are treated at the hospice and in the community based upon clinical need, regardless of background and the ability to pay. The service provides specialised care for those over 18 years of age.

LOROS specialises in holistic, multidisciplinary care, focused on the whole person and including spiritual needs as well as the patients' own choices. Family members are supported in adjusting to loss and bereavement. Access to care can be via:

- Short-stay in-patient care for symptom management and end of life care
- Palliative day therapy
- In-patient ward
- Day therapy services
- Out-patient services
- Outreach services

LOROS contributes to the education and training of its own and other health and social care professionals and volunteers. The charity is also committed to research to improve the understanding and practice of palliative care.

The service has been registered with CQC since 31 January 2011, for the regulated activity of treatment of disease, disorder or injury.

The service has a registered manager who has been in place since August 2022.

Our inspection took place on the 10 January 2024. The inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We observed care and treatment during our inspection, looked at 3 sets of medicines administration records and 3 sets of patient notes. We spoke with 18 members of clinical and non-clinical staff including members of the executive team. We looked at compliments received by the service as well as patient feedback surveys.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. The team inspecting the service comprised a CQC lead inspector, a CQC inspection manager and an expert by experience in the area of end of life care.

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>.

Summary of this inspection

Outstanding practice

- The service was entrepreneurial and pioneering in their approach to innovation, research and improving patient care.

Our findings

Overview of ratings

Our ratings for this location are:

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

Hospice services for adults

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

Is the service safe?

Good 

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

Mandatory training

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

Staff received and kept up to date with their mandatory training. Mandatory training modules were a mixture of face to face and online training. At the time of our inspection mandatory training compliance levels for all hospice based staff was 88.9%, which exceeded the hospice's target of 85%.

Mandatory training was comprehensive and met the needs of patients and staff. Modules included but were not limited to, safeguarding adults and children, equality, diversity and human rights, mental capacity act and the deprivation of liberty safeguards and infection prevention and control.

Bank and agency staff, as well as volunteers also completed the hospice's mandatory training programme.

Staff told us they had protected time to complete their mandatory training. The clinical nurse educator, specialist champions and ward managers were responsible for monitoring mandatory training completion and received reports from the learning platform to ensure that staff were up to date.

Safeguarding

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

The service had both adult and children safeguarding policies. The organisation performed to the standards set for training and competency from the Local Safeguarding Boards, production of evidence for the Care Quality Commission and the Integrated Care Board.

Hospice services for adults

Safeguarding training compliance was 100% for all clinical staff including staff and doctors. As clinical staff they had all received safeguarding adults and safeguarding children training level 2. All clinical staff with a clinical qualification had completed higher levels of training as determined by the intercollegiate guidelines.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with were able to define safeguarding protocols and understood who to contact with safeguarding alerts when they had concerns.

Staff followed safe procedures for children visiting the service.

Staff provided examples of safeguarding referrals that had been made just prior to the inspection and were able to explain how these safeguards were managed and investigated. We saw staff worked closely with external health care professionals to share safeguarding concerns including district nursing colleagues and social care organisations. Safeguarding training completion levels for non-clinical staff were 97%.

The service had a safeguard lead post which was in active recruitment. As a result, the service had reviewed their provision arrangements for this role. These included accountability by the director of patient services and additional operational support by social workers who worked onsite. All accountable staff were trained to level 3 in adults and children safeguarding.

We reviewed adult and children safeguarding policies and saw that all volunteers (when in post) also received safeguarding training. At the time of the inspection volunteers were working in areas, such as reception, fundraising and administration and in the inpatient unit and these had all completed both adults and children safeguarding.

Staff files had full Disclosure Barring Service (DBS) checks and we were informed all results were appropriate for the roles being undertaken. The human resources process staff followed, and the electronic system in use did not allow for any member of staff to be offered a start date without all documentation in place including a satisfactory DBS check, references or interview record.

The service worked with social workers who promoted safeguarding and supported staff when making and reviewing safeguarding referrals. They provided supervision and assistance with the safeguard referrals to ensure that these were completed and actioned correctly. They also monitored safeguards with the local authority for follow up.

Cleanliness, infection control and hygiene

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

We reviewed the service's infection, prevention and control (IPC) policies and procedures and we found them to be up to date and in line with national guidance. The service's IPC policy made reference to national guidelines, such as the National Infection Prevention and Control Manual for England. In line with this guidance the policies and procedures followed principals, such as standard infection control precautions and transmission based precautions. Other procedures, such as the use of specialised equipment (for example syringe pumps) also referenced national IPC measures and guidance.

The hospice reported 1 episode of healthcare-acquired infection or outbreak during the past 12 months. This related to an outbreak of COVID-19 in December 2023. The outbreak was managed in conjunction with the local acute NHS trust.

Hospice services for adults

The inpatient ward, sluice room, treatment room, day therapies area and patient and relatives' communal rooms and dining areas were visibly clean and had suitable furnishings which were clean and well-maintained.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. As an example, the inpatient unit was bright and visibly clean. Patients had access to 19 separate rooms, with en-suite bathrooms, or, if requested or patients required closer monitoring they could be allocated to the 1 of the 3, 4 bedded bays. Hand washing facilities and hand sanitisers were available in patient rooms, throughout the ward, and the hospice as a whole.

We reviewed the results of the last audit completed for IPC and hand washing for the period of July to December 2023 and saw that compliance levels were 96.2% for the inpatient ward, 96.7% for the day therapy area and 100% for the outpatient and lymphoedema area.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. Housekeepers used detailed cleaning checklists, tailored with specific tasks for every shift. Staff signed and dated each task as it was completed and there were no gaps in the signing of any records we reviewed. Room checks and spot checks were completed by the inpatient sister.

Staff followed IPC principles including the use of personal protective equipment. We reviewed audit tools used between October and December 2023 with the respective compliance rates of 94.1%, 85.7% and 98.9%.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned using 'I am clean' stickers.

Unused water outlets were flushed regularly to minimise the risk of Legionella.

Patients with a known infection could be isolated in single rooms with use of universal precautions signage to minimise risks for staff and visitors.

All observed sharps bins we observed were assembled correctly, dated, signed and not overflowing. Collection and disposal of sharps bins was done via an external waste management agency.

Environment and equipment

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

The service had suitable facilities to meet the needs of patients, families and carers. The design of the environment followed national guidance and patients could be offered 19 individual rooms, if required and risk management was safe. The service also had 3 bays with 4 beds in the inpatient area. Each bay bed had privacy curtains and if required the patient and family could access one of the family rooms or patient areas for more privacy. The environment was light and bright with comfortable furniture and the surroundings were decorated with artwork. Patients could easily reach call bells and staff responded quickly when called.

The outpatient area had several consultation rooms appropriately equipped for the procedures undertaken by the service. Additionally, the day therapies rooms were appropriately equipped to support the delivery of care.

Hospice services for adults

All equipment was serviced and checked by the maintenance team and a service level agreement and schedule of works was kept up to date. The service had enough suitable equipment to help them to safely care for patients.

Staff carried out daily safety checks of specialist equipment. Syringe pumps were serviced and tested, and staff knew how to report any concerns with specialist equipment. We reviewed the resuscitation trolley and saw that regular checks of the equipment were in place. All items were checked including emergency medication, sharps, blood glucose monitoring equipment, and clinical supplies. These were all in date.

Single use, sterile instruments and consumable items were stored appropriately, and we saw these were within their expiry dates. Staff handled, stored and disposed clinical waste (and sharps) safely.

The service had a policy in place to support the admission of bariatric patients. Furniture for use by patients with bariatric needs could be easily accessed and hired. Guidance stated they could request this within hours of a referral so that everything was provided and in place before the patient arrived.

Staff disposed of clinical waste safely. A service level agreement for safe disposal was in place. We saw the use of colour coded laundry bags and bin bags for the disposal of clinical waste. Clinical waste was also double bagged and stored externally in an access-controlled area.

Health, safety and welfare training was provided to all staff during their induction. Staff told us the training supported LOROS' health and safety policy, rules and responsibilities, and gave practical guidance on how to look after themselves, and others, at work.

We saw that all chemicals were stored securely and appropriately in line with Control of Substances Hazardous to Health Regulations 2002.

The service had access to transfer and mobility equipment including hoists and ceiling track hoists in some of the individual bedrooms. The facilities management team had an electronic log of all the equipment and monitored any equipment that had been reported as faulty or was due servicing. They were responsible for contacting the equipment providers to arrange for repairs.

The hospice was at ground floor level and there were no stairs, the doors to access each area were electric and wide enough to allow wheelchair and bed access. The doors and fire equipment were in line with requirements with doors having the right seals, closing mechanisms and interior lining for area fire protection. The fire extinguishers we saw were all in date and had powder and CO2 extinguishers available.

The service had a mortuary facility, but we did not visit it as part of our inspection.

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 completed risk assessments for each patient on admission to the ward, using recognised tools. Patient records included risk assessments, such as those for pressure ulcers, nutritional needs, risk of falls, moving and handling and infection control risks. These were reviewed and updated periodically on a weekly basis or sooner if there had been any change to the patient's condition.

Hospice services for adults

The service monitored care and learnt from risk assessment audits. We reviewed the service's audit tools and results for pressure ulcers and falls and found that the audit tools were appropriate and comprehensive to identify areas of good practice and learning. Results for both audits between July and December 2023 were 92.5% and 81% respectively with compliance with the standards. As a result of the findings of the falls audit the service implemented action plans and outcomes that were reviewed regularly to improve the outcome of their falls management practice.

Staff understood how to identify patients with suspected sepsis, including neutropenic sepsis. Staff told us about any patients with suspected sepsis would be immediately transferred out to the local NHS acute hospital by emergency ambulance. There had not been any instances in the past 12 months where a patient required transfer to hospital for suspected sepsis.

Staff used an adapted nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff knew about and dealt with any specific risk issues. Patients had person-centred care plans in place, so they received the right level of care at the right time. Staff carried out frequent patient observations so any changes to the patient's medical condition could be promptly identified. We looked at 3 patient records and these showed that patients were reviewed regularly and escalated appropriately for medical input when required.

If a patient became unwell and required hospital admission for an acute event that required investigation or treatment that the hospice was unable to provide, then they would be transferred to an NHS acute hospital.

Shift changes and handovers included all necessary key information to keep patients safe. Staff also carried out daily safety huddles at the start of the day to discuss key patient risks. In addition to physical risks, other points were discussed and documented as part of the handovers and were documented in the patient risk assessments and patient care notes. These included discussion on mental health, enablement, nursing and medical plan (including ceiling treatments and complex care).

Staffing

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

The service had enough nursing and support staff to keep patients safe. The areas we inspected had enough trained nursing and support staff with an appropriate skill mix to provide care in line with national staffing guidance. Managers were aware of the need to ensure patient care met standards of staffing and would manage the number of admitted patients and flow if staffing numbers couldn't support safe care.

Nurse staffing levels were based on the 'safer staffing' acuity tool. Managers accurately calculated and reviewed the number and grade of nurses, nursing associates and healthcare assistants needed for each shift in accordance with national guidance.

At the time of inspection, we saw that the service had enough medical, nursing and support staff to keep admitted patients safe. The inpatient unit accommodated a maximum of 31 patients, and we saw the actual number of nurses and healthcare assistants matched the planned numbers for the admitted patients.

Hospice services for adults

The day therapies service was staffed with 4 registered nurses, a nurse associate, a senior healthcare assistant and 5 healthcare assistants, alongside administration and complementary therapy services staff. The clinical nurse specialist team had 12 specialist palliative care nurses, alongside the clinical lead and deputy lead.

To support the provision of clinical services the service had an enablement team which supported the delivery of care in all areas of the hospice. The team was made up of 2 enablement leads, 2 deputy leads, 2 occupational therapists, 2 physiotherapists, 2 social workers, 1 liaison officer, 1 therapy assistant and an administrator.

The hospice had a pool of volunteers that supported the clinical and non-clinical areas (such as fund-raising, befriending and support) of the hospice. Volunteers involved in any patient care underwent recruitment checks and had appropriate induction and training. Volunteers provided companionship and helped patients at the hospice, such as during mealtimes and when visiting the garden or other communal areas.

The service had enough medical staff to keep patients safe. The medical staff on duty matched the planned number for the number and acuity of patients. Medical staffing consisted of 5 doctors during normal hours (9am to 5pm), with 1 to 2 registrars and 3 to 4 junior doctors. Out of hours the service was supported by 1 registrar or junior doctor. The service had an agreement with the local NHS trust to have a consultant on call at all hours.

Doctors attended daily ward rounds. The 3 hospice ward-based consultants did 2 ward rounds a week. On Thursdays there was a ward round multidisciplinary team meeting with a consultant, which aimed to provide holistic care for patients and clarify their preferred place of death.

The hospice did not directly employ the medical team as doctors and consultants were directly employed by the local NHS trust. Some of the work of the medical team took place outside the hospice and within the specialist palliative care teams in the community and acute hospital NHS Trusts.

Managers could adjust staffing levels daily according to the needs of patients and would request additional healthcare assistants to support patients with 1 to 1 care or 1 to 2 supervision, if this suited the needs of the patients. All staffing was planned and organised around patient needs rather than organisational, financial, or environmental requirements.

Managers limited their use of bank and agency staff however, all agency staff were familiar with the service. All bank and agency staff had a full induction and understood the service.

The inpatient matron and the director of patient services and clinical quality could also work clinically if and when necessary to support staff care for patients' safety.

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 all staff could access them easily. Records were stored securely.

Staff used mostly electronic-based patient records for recording risk assessments, consent, discharges, care plans, patient assessments, and observations and for daily medical and nursing notes. When patients transferred to a new team, there were no delays in staff accessing their records.

Hospice services for adults

Records for patients receiving community-based care were kept within their homes or places of residence and shared with other health professionals, such as district nurses. The hospice maintained electronic records for community-based patients detailing patient information, such as contact details, risk assessments and care plans.

The ward staff used electronic-based records for standardised nursing activities, such as for daily vital observations and nutritional care. We saw that observations were well recorded, and the observation times were completed at regular intervals matching the level of care requirements needed by the patient.

We looked at the records for 3 patients based in the ward. These were well structured, legible, complete and up to date. Patient records showed that nursing and clinical assessments were carried on admission to the services. We also saw that patient risk assessments were reviewed and updated at established regular intervals unless there were any changes to patient needs.

Multidisciplinary staff interventions were recorded in daily notes, and these were up to date.

We found that patient's care plans, including ceiling treatment plans and complex care plans, were person-centred and were completed to a good standard. Person-centred care plans were in place, such as identifying risks and management for falls, pressure care, pain management, medicines management, urinary catheters, smoking management, nutrition and hydration and personal care wishes. The records we looked at included care plans that were up to date and had been reviewed in line with local policies and procedures, such as Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), mental capacity assessments, organ donation and care after death plans.

Staff carried out routine audits of patient records to check for accuracy and completeness. We looked outcomes for patient record audits from July to December 2023 with compliance against the audit standards being rated at 92% for this period. The audits identified areas for improvement, such as entries not always being timely. Other areas for improvement included reviewing some of the templates and care plans to make it easier for staff to share and complete these in a more holistic manner.

Medicines

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

The service had a medicines management policy that was comprehensive and met the needs of the service. The policy was within date and followed national guidance in areas, such as receipt of medicines procedures, supply and ordering of medicines from pharmacy, administration of medicines and removal and disposal of medicines.

Staff followed systems and processes to prescribe and administer medicines safely and to check patients had the correct medicines. Staff carried out daily checks on controlled drugs and routine medicine stocks to ensure that medicines were reconciled correctly. We looked at a sample of controlled drugs and found the stock levels were correct, and the controlled drug registers were completed correctly.

We saw a morning drug round completed by 2 people, with staff on the rounds using red tabards to ensure they were not interrupted during their processes. Staffing arrangements were 2 full time pharmacy technicians present between 8:30am to 5:30pm with access to pharmacist on call in that time and out of hours.

Hospice services for adults

Staff reviewed each patient's medicines regularly, provided advice to patients and carers about their medicines and kept records up to date. Prescribing was clear, safe and appropriate in response to symptoms that patients experienced during their stay. When medicines were not administered, reasons were clearly recorded in the electronic prescribing system. There was evidence of medicines being appropriately titrated to respond to patients' increasing symptoms.

The service had systems that provided clear and easy communication between clinical staff in respect of medication administration and checks for each patient, observations and storage of patients' own controlled drugs. This meant that if a staff member who was caring for a particular patient was suddenly not available, all other staff were able to know what time medication was last administered, what was next due and when and what observations had been completed or were required.

Staff stored and managed all medicines and prescribing documents safely. Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. The service had a system to check (medicine reconciliation) the medicines the patient was taking throughout their admission and a detailed reason was recorded for why a medicine had been stopped, started, or a change in dose. This allowed a detailed discharge letter to be produced, which gave a correct list of medicines to be sent to the patient's GP.

The service supported the safe management and prescription of anticipatory medicines. These medicines were tailored to the needs and condition of the patients. The service also provided information leaflets and instructions and guidance on the safe storage and administration of these medicines.

The service audited medicines storage and the management of controlled drugs. Between July and December 2023, the service scored 97% and 100% respectively, against the measured standards.

We saw fridge temperatures were recorded through a centralised system and managed well. Variances to the acceptable fridge temperature range were highlighted to staff and instructions on what to do should temperatures not fit the required range were clear and well managed by the pharmacy team.

We observed 'safety huddle' documentation and found information about patients' symptoms, medicine choices and non-pharmacological measures were discussed between all members of staff. Staff learned from safety alerts and incidents to improve practice.

Medical gases were stored appropriately.

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.

We reviewed the service's incident reporting and management policy (including serious incidents) and found it to be up to date, comprehensive and in line with reporting guidelines.

Staff knew what incidents to report and how to report them. We saw the service used an electronic database system for logging and monitoring incidents. Staff had received training for this system. Staff we spoke with knew what incidents to report and were able to articulate how they should be reported in line with the service's policy.

Hospice services for adults

Incidents were reported and had oversight from staff and the senior management team through the clinical governance meetings. Trend analysis and themes were seen in this meetings and actions developed to address any concerns.

The service had no never events on any areas. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. The event has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.

The service reported 619 incidents between January and December 2023. All incidents were graded and investigated. The service reported 1 incident with the level of death, 1 incident as severe harm, 89 as moderate harm and the remaining incidents as low, no harm or near misses.

The death incident was reported accordingly to external organisation, such as the CQC and an ongoing review was in place. Initial learning and outcomes from this incident had already been implemented to the service practice to avoid recurrence, and we were told that the review was being done in line with the duty of candour and impartial review system. Staff told us that managers debriefed and supported them after any serious incident.

Managers and staff understood duty of candour and there was a duty of candour policy in place. Staff were open and transparent and gave patients and families a full explanation if and when things went wrong.

The senior managers were aware of their responsibility to report notifiable incidents to the CQC and other external organisations.

There was a system in place to ensure safety alerts relating to patient safety, medicines and medical devices were cascaded to staff and responded to in a timely manner. Governance processes supported the safe and timely dissemination of this information.

Staff met to discuss the feedback and look at improvements to patient care and there was evidence that changes had been made as a result of feedback.

Is the service effective?

Good 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients 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. Policies and procedures were based on national guidance, such as those from The National Institute for Health and Care Excellence (NICE), Royal Colleges and other relevant bodies.

Hospice services for adults

Patients had an individualised care plan which, if the patient was at end of life, was supported by the individualised care and communication record for a person in the last days or hours of life. This was in line with NICE guidelines and quality standards, such as QS13 (End of life care for adults) and NG31 (Care of Dying Adults in the Last Days of Life).

Staff protected the rights of patients subject to the Mental Health Act 1983 and followed the Code of Practice. Patients and their relatives were supported by the counselling team for psychotherapy and emotional support. Patients could also be referred to the local specialist NHS mental health services for advice and support.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. The multidisciplinary safety huddle could be attended by bereavement counsellors and chaplaincy representatives to review and discuss patients' spiritual, psychological, and emotional needs. This met the care of dying adults in the last days of life Quality standard 144.

Changes to clinical practice, national guidance and policies were reviewed and developed through routine clinical governance meetings and shared with staff.

Policies and procedures reflected current guidelines and staff told us they were easily accessible in electronic format. We looked at a selection of the policies and procedures and these were up to date and based on current national guidelines.

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, including those with specialist nutrition and hydration needs. Staff used a screening tool to monitor patients at risk of malnutrition. We saw this was appropriately completed in the care records of patients we looked at. Guidance was available to support staff with encouraging people with life-limiting illnesses to eat.

The hospice hospitality team worked to provide the best nutrition and meals possible and spent time with patients listening and planning meals, snacks and drinks to suit their needs and wishes. Staff told us they would offer dietary choices in accordance with patient's cultural or religious choices. The team worked together with speech and language therapists and nutritionists to provide foods with specified textures, such as purees or thickened drinks.

A nutrition and hydration audit was carried out every 6 months to monitor if during patients' admission they were given choice, enough access to food and drinks, and if they had received any help they may have required. The survey was used to improve catering services and monitor the provision of nutritional needs during care episodes.

We observed that patients' fluid and nutrition charts were completed appropriately. In all 3 of the patient's fluid balance charts we reviewed, we saw staff recorded fluid measurements properly. Staff used this information to prevent or correct dehydration and fluid overload. Patients were weighed for dietary purposes and staff assessed weight loss or gain as part of their stay at the hospice.

We saw patients had water provided within reach and staff offered drinks to patients and their visitors throughout the day. Patients and their relatives were offered complementary teas and small snacks during the day.

Hospice services for adults

The service considered ways in which to meet the nutritional needs and personal choices of patients approaching end of life. Staff helped patients record their preferences about eating and drinking in their advance care plan and supported and advised them of possible ways in which to do so. Options considered varied from reviewing dietary needs and consistency of food depending on the patients' swallowing abilities, religious and cultural needs and appetite, to supported nutrition and hydration, such as artificial enteral nutrition. Artificial enteral nutrition involves inserting a tube into the gut and liquid nutrition is given through this tube.

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. Patients received pain relief soon after requesting it. Staff prescribed, administered, and recorded pain relief accurately.

Patients were asked how their pain levels were, following administration of analgesia and recorded the information as part of the integrated palliative outcome scale (IPOS) scoring system. In addition to this the service was looking at ways to directly audit pain management. They had identified this due to a tool being updated on their electronic patient system and the audit not meeting these changes. Management of this documentation was part of a steering group action plan.

We reviewed the clinical assessment for all patients at the point of admission and we saw that assessments were recorded for risks associated with pain management.

Staff discussed pain management with the multidisciplinary team. We also observed patients were comfortable and at rest during our visit to the hospice.

Patients we spoke with advised that their pain was managed well. We reviewed information provided by the IPOS which was a patient reported outcome questionnaire that aimed to capture the difference that healthcare makes for patients and families. One of the symptoms surveyed was pain and the survey showed that there was an 11% improvement in pain management for inpatient patients and 4% improvement in pain management for day services. However, outpatients' services showed a deterioration in pain by 23%. The period reviewed covered patients who had been admitted and discharged in the time frame between July to December 2023.

Patient outcomes

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

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The clinical audit programme and associated actions were delivered and monitored by the hospice governance structures which reported directly into the clinical governance and development committee which was a board committee with delegated authority of the board of trustees.

Hospice services for adults

Audits completed were positive, consistent and met expectations, such as national standards. As an example, the IPOS showed an average 3.7% improvement in the 17 metrics for all 3 services provided by the hospice between July and December 2023. The service also audited outcomes for the recommended summary plan for emergency care and treatment (ReSPECT), do not attempt resuscitation (DNACPR) and number of patient deaths.

Of the 845 individual patients who were seen across the inpatient ward, medical outpatients, motor neurone disease service and day therapy services between July and December 2023, 68.4% had a recorded option to attempt or not resuscitation. Of these 92% were identified as DNACPR.

During the period between April and December 2023, the hospice reported there had been 269 patient deaths, of which 232 patients had a documented preferred place of death. The hospice achieved the preferred place of death for 85% of these patients. This showed the hospice was able to meet the wishes of most patients who had specified a preferred place of death. The hospice also recorded why the patient did not die at their preferred place of death, with the reasons varying between the decision being unrecorded, the patient being undecided or unable to express preference, or if the patient declined or the discussion was not appropriate.

The service networked with other hospices to align audits and for the purposes of local benchmarking within the network. Managers and staff used the results to improve patients' outcomes and made sure staff understood information from the audits.

We saw the service submitted data relating to pressure ulcers, medication incidents and falls to Hospice UK and used this as a benchmark in which to monitor some patient outcomes and aid improvement.

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.

Managers gave all new staff a full induction tailored to their role before they started work. Newly appointed staff had a 2-week induction with the practice development team. During this period the service supported the development of skills, competencies and training for staff with the use of competency sign off sheets. Bank and locum staff also had inductions before starting work.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us they received an annual appraisal that supported their development and training needs with the appraisal supporting both organisational and personal development needs. Appraisal completion rates for eligible medical staff was 100% for the current year and for eligible clinical staff was 82.8% completed with the remainder of staff in progress of completing their annual appraisal, which demonstrated most staff had completed their annual appraisal.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. As an example, all medical staff had specialist training and additional qualifications in palliative care medicine. Another example was that the counselling team were registered with the British Association for Counselling and Psychotherapy.

Hospice services for adults

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff undertook competency-based training and attended specific training and workshop sessions covering a range of topics, such as for wound management, oral care for head and neck cancer patients, medicines management, use of specialist equipment and for patient symptom management, such as pain, breathlessness and advanced care planning and communication.

The service supported staff with key treatment advice. The service had a series of policies outlining best practice and promoted champions to support the management of staff queries. As an example, the service had a tissue viability nurse, motor neurone disease, tracheostomy, tissue donation, infection prevention and control and documentation champions.

The hospice reported there were no outstanding queries relating to General Medical Council and Nursing and Midwifery Council registrations and revalidations.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers involved in any patient care underwent recruitment checks and had appropriate induction and training prior to working with any patients.

Staff were positive about on-the-job learning and development opportunities and told us they were supported well by their managers.

Multi-Disciplinary Working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff worked together to ensure patient information was shared. A number of meetings, such as patient's safety and safeguarding meetings were held to ensure key information was known to all staff.

Multidisciplinary discussions were effective and included key discussions, such as symptom control, safeguarding, escalation plans, falls risk, diet risk, skin risk, DNACPR choices and patient deterioration outcomes. Discussions also covered approaches to family inclusion and patient involvement. We observed that symptom control discussions included patient feedback. Staff told us they received good support from pharmacists, dietitians, physiotherapists as well as the pastoral, counselling, and bereavement teams.

Staff worked across health care disciplines and with other agencies when required to care for patients and sought information from national organisations, such as Hospice UK. There was routine multidisciplinary working between the medical staff and external NHS hospital staff and general practitioners (GP's) to discuss patient's care and treatment. Ward staff and clinical specialist nurses also liaised with a number of different services when co-ordinating patient care. This included GP's, adult social care providers, district nursing teams, hospitals, community services and social services.

We heard how social workers provided support and advice to patients and those close to them. This included (but was not limited to) advice and support in getting wills written, benefits, power of attorney, as well as ensuring safeguarding arrangements were relevant and appropriate.

Hospice services for adults

Ward staff told us they had a good relationship with the medical staff and that they received good support from stewards, volunteers, porters and catering staff. We saw there was effective team working and communication between staff across all disciplines.

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/units. The hospice had a range of information leaflets to provide support and advice for patients around healthier living. Leaflets available included but were not limited to information about your stay, compassionate neighbours. Lymphoedema services, reaching out, day therapy services, guides to end of life care and information about the integrated community specialist palliative care team.

Staff assessed each patient's health when admitted to the hospice services and provided support for any individual needs. Staff told us they routinely discussed health promotion and lifestyle choices with patients. For example, patients identified as being overweight, patients at high risk due to high alcohol consumption or patients that were smokers were given advice and support, including on how to refer or gain access to external NHS services.

Seven-day services

Key services were available 7 days a week to support timely patient care.

The inpatient ward operated 24 hours a day, 7 days a week. The ward accommodated overnight patients 7 days per week and staffing levels were suitably maintained during out-of-hours and weekends.

The medical staff led daily ward rounds on the inpatient ward, including weekends.

Patients could be admitted to the ward 7 days per week, including during out of hours service with support from on-call medical staff.

The community specialist teams operated 7 days per week during the daytime, with a with night sitting service from a partner organisation available for patients requiring overnight support. There was a 24/7 emergency support helpline available for patients and their relatives if they required any support and guidance.

Allied health professional support, such as physiotherapy and occupational therapy support was available on site during normal hours on weekdays. The hospice had access to speech and language therapy and dietitians from the local NHS trust and these were responsive and supportive.

The day therapies unit provided sessions four days per week during routine working hours. The bereavement and counselling teams operated during normal working hours on weekdays.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Hospice services for adults

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff made sure patients consented to treatment based on all the information available and clearly recorded their decision. When patients could not give consent, there was an established order to how decision were made with support to consent initially attempted, then consideration of any lasting power of attorney, and finally staff making decisions in the patient's best interest. These decisions considered patients' wishes, culture and traditions. We looked at 3 patient records which showed that patient consent had been obtained and planned care was delivered with their agreement.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. If a patient lacked the capacity to make their own decision, staff told us they sought consent from an appropriate person that could legally make decisions on the patient's behalf.

The provider's Assessment of Mental Capacity Policy was up to date and reflected national guidance. The policy clearly referenced how the contents of the policy should be used alongside the Mental Capacity Act (2005) Mental Capacity Act Code of Practice (2007) and relevant LOROS policies, such as the safeguarding of adults, advance care planning, deprivation of liberty and adult restraint service policies.

Staff received and kept up to date with training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. Staff could describe and knew how to access the policy and get accurate advice on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). The process for the application of DoLS was robust and had relevant safeguarding gateways to ensure the correct processing and recording of the DoLS.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Mental Capacity Act Code of Practice (2007) and they knew who to contact for advice. The hospice social work team maintained a spreadsheet to provide a further layer of monitoring of DoLS. The team also had responsibility for notifying the relevant supervisory body when a DOLS had ended; usually this is when a person has died or has been discharged. The social work team were also responsible for completing a CQC notification when a DOLS had ended and were the primary point of contact for the DoLS teams if they had any queries.

The service monitored the use of the Mental Capacity Act and DoLS and made sure staff knew how to complete forms appropriately. Staff implemented DoLS in line with approved documentation. Between July and December 2023, 33 DoLS forms were submitted for approval by the local authority.

The service provided training in advanced care directives and staff understood how this was integrated with personalised care planning. Staff had awareness of the importance of communication skills and behaviours that underpin end of life conversations and felt confident in approaching these discussions. We also heard how staff were supported and had training to approach advance care planning discussions and communicating decisions about DNACPR with patients and carers.

Is the service caring?

Hospice services for adults

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

Compassionate care

People were respected and valued as individuals and as partners in their care, practically and emotionally.

Staff were empowered to treat patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff regularly took time to interact with patients and those close to them, in a respectful and considerate way.

The environment on the inpatient unit was quiet and calming and we saw patients were relaxed during our inspection. This was also reflected throughout the rest of the hospice environment. Staff were observed completing visual checks whilst patients were at rest and assistance was offered in between the patients using the call bell.

Most patients were cared for in individual rooms. Some patients, either by preference or through risk assessments were treated in a 4 bedded bay. We saw staff always maintained the patients' dignity and privacy whilst assisting with personal care needs and during sensitive conversations while being aware of their environment and finding the right time and space to do so.

The service actively sought feedback from patients and those who used the service. Feedback from people who used the service and those who were close to them was continually positive about the way staff treated people. People thought that staff went the extra mile, and their care and support exceeded their expectations. We saw feedback which said, "The gentle smiles, humour and understanding from all staff coupled with listening and levels of care to support me were outstanding" and "I've had the best care ever, no problems with anyone. LOROS is a perfect place to be. I couldn't have been treated any better, it's like having a holiday in a top hotel".

We reviewed recent feedback questionnaire summaries and saw that between July and December 2023, 99% of patients said they were treated with kindness and respect. We saw thank you cards displayed around the ward area which reflected this.

There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by all leaders in all the services provided by the hospice.

Staff recognised and respected the totality of people's needs. They always took people's personal, cultural, social and religious needs into account, and found ways to meet them, such as preferred food options, chaplaincy support and creative ideas too. Patients and their relatives who we spoke with were very complimentary and full of praise when describing the care and support they received from staff across the hospice. We found numerous examples that demonstrated how staff went the extra mile for patients and their care and support exceeded their expectations. This included a nurse supporting a patient with complex neurological conditions out of hours to complete their dream of running a 10km race and enjoying the feeling of being reconnected with their community and fulfilment of raising money for charity. Other exceptional patient stories included nurses helping a patient celebrate their last birthday with a spa morning and cake. The family said they would never forget that day.

Hospice services for adults

The day therapy services at the hospice supported people living with a range of conditions including cancer, respiratory disease, heart disease and neurological conditions, such as motor neurone disease (MND). They helped people cope with the physical, psychological and emotional demands of their condition and live their lives, as well as possible as their illness progressed. This was a safe and tranquil space within the hospice which had access to a restful, sensory garden and had facilities for refreshments, and free parking.

The hospice provided complementary therapies and a series of short programmes to help patients cope with their illness and develop effective self-help techniques to manage symptoms.

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. People's emotional and social needs were seen as being as important as their physical needs. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. 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 hospice counsellors were specialists in providing bereavement counselling and support for those experiencing grief after someone dies from a life-limiting progressive illness like cancer, a chronic heart or lung condition or MND. They provided both pre- and post- bereavement support, which was deemed especially important for children. The team were experienced in helping children to work through their grief and the feelings and thoughts they had relating to their loss.

Chaplaincy support was seen as essential to the hospice. The spiritual care team shared this role and could provide support to staff and patients of all faiths. As well as the spiritual support offered through the external 'chaplaincy and listening service'. Religion, spirituality and existential issues were often brought into the counselling sessions and clients had the opportunity to explore these issues.

The service had guidelines and access to multifaith leaders who supported people and their families in their dying days. The service took into consideration the principals, beliefs and end of life care beliefs from each religion.

Bespoke experience sessions for patients and those close to them were arranged by the whole staff team. Experiences included, for example, trips out of the hospice with family and friends. We found that it was not unusual for therapy animals and pets to visit or for the hospice service to spend time with the patients.

Staff chatted to every patient referred to the inpatient unit, day therapy service and outpatient services and assessed their needs to design an individual package of wellbeing support to suit them. Staff also offered advice and support services online, over the telephone and in person.

Complementary therapies and a series of short programmes were available with group work facilitated to help patients cope with their illness and develop effective self-help techniques to manage symptoms and challenges in their own way.

As part of the feedback questionnaire the service asked if people had been looked after in the way they wanted to. Between July and December 2023, 96% of patients said this was the case. Feedback also included comments, such as:

Hospice services for adults

“This was my first experience of counselling and before this I didn’t know where to turn to or how to deal with the level of grief I was feeling. My sessions helped me to focus and realise there was no time limit to how I should feel. I have learnt coping techniques and now feel like my old self again and that the dark blanket has lifted.” And “Day Therapy made my fear disappear and made me laugh. I went out with a smile on my face, I didn’t expect that!”

The service had special events and memorial events for bereaved children and families. For example, the service commissioned an artist to design a bespoke Tree of Life sculpture, in which one of the 1,500 individual leaves represented a loved one. The service also had other memorial initiatives, such as the Twilight Walk, in which families and the bereaved dressed up as superheroes in a 10 km walk across Leicestershire city to remember their loved ones and raise awareness for hospice care.

Understanding and involvement of patients and those close to them

Staff saw people, who were approaching end of life, and those close to them as active partners in their care. Staff were fully committed to working in partnership with patients, families and carers to make this a reality for each person.

People who used the hospice services and those close to them were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person. Staff always empowered people who used the service to have a voice about their care and treatment and to realise their potential by encouraging small daily achievements. They showed determination and creativity to overcome obstacles to delivering care and people’s individual preferences and needs were always reflected in how care was delivered.

Relationships between people who use the service, those close to them and staff were strong, caring, respectful and supportive. 95% of people responded positively to the patient feedback questionnaire when asked if they were involved in decisions about care. This feedback questionnaire was sent to patients, families and carers.

Patients we spoke with told us they were kept informed about their care and treatment and staff were clear at explaining to them in a way they could understand. Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Survey feedback from patients and their relatives showed 100% of patients, their relatives and carers would recommend the hospice to family and friends.

We were informed about the admission process to the inpatient unit and heard how family members were involved in the admission and assessment process. We saw electronic care records stating that both medical and nursing staff had spoken with families regarding changes in care needs and clinical needs.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff supported patients to make informed decisions about their care.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service.

Is the service responsive?

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

Hospice services for adults

Service delivery to meet the needs of the 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.

Facilities and premises were appropriate for the services being delivered. The design and layout of the 31 bedded inpatient ward promoted accessibility in all areas with most patient rooms facing out to the gardens which surrounded the hospice.

The hospice grounds had extensive gardens and open communal and quiet areas to provide patients and their relatives with a calm and relaxing environment.

The hospice provided a range of services including the inpatient ward unit, day therapies services, medical outpatient appointments and specialist palliative community services.

The hospice had policies which outlined the admission criteria for patients. Most patients admitted for these services were palliative care patients (patients with a life-limiting illness), aged over 18 years of age and resided within the hospice's geographical catchment area.

Managers planned and organised services, so they met the needs of the local population. There were daily safety huddles so patient flow could be monitored and maintained, and to identify and resolve any issues relating to the admission, discharge and death of patients. The hospice had a coordinated admissions process that reviewed patient referrals and admissions daily.

The hospice had an education team that formed part of the hospice team. The education team provided specialist palliative care training and support for hospice staff and to professionals across the local area. The team provided specialist palliative care education to a range of professionals across the local area, as well as specific palliative care training for in-house staff and other professionals, such as general practitioners (GP's), care home staff and NHS staff.

The service had systems to help care for patients in need of additional support or specialist intervention. The inpatient ward and specialist community teams were led by medical staff and supported by the nursing teams. The hospice offered a counselling and bereavement service and also had in-house specialist support, such as from the multi-faith spiritual and pastoral team, physiotherapy, occupational therapy and creative therapies teams. Patients could be referred for specialist care, such as speech and language therapy, tissue viability nurses, dietitians and counselling to support for patients and family members with emotional needs.

The specialist palliative community nurse teams had caseloads that were linked by GP catchment area, and they worked closely with district nurses, adult social care providers and GPs to provide care and treatment for community-based patients referred to the hospice.

There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met these needs, which was accessible and promoted equality. Staff across the hospice routinely engaged with the local community, including ethnic minority groups, community groups and other vulnerable groups, such as homeless people and the local traveller community.

Hospice services for adults

The hospice's engagement team provided a range of specialist training to staff across local acute NHS services, primary care service providers, adult social care providers and local community members to raise awareness of the services provided by the hospice.

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 services.

People's individual needs and preferences were central to the delivery of tailored services. Upon referral or admission to the service, staff developed detailed person-centred holistic care plans which took into account all aspects of the patient's care including end of life plans and care. Each person's care plan was devised in discussions with the patient about what was important to them. The care plans were regularly reviewed and updated, and referrals were made to members of the multidisciplinary team according to each patient's needs.

The hospice used a tailored care and communication record to document each patient's care at the end of life. This included any advanced care plans, or advanced decisions to refuse treatment that had been put in place by the patient.

The hospice supported open visiting for relatives and carers seven days a week. Patients told us visitors to the hospice were always offered refreshments, such as tea, coffee and snacks.

The service had suitable facilities to meet the needs of patients' families. The hospice had a number of quiet rooms that were suitably furnished to a very good standard and could be used by patients and their relatives. The hospice had 3 relative suites that could be used for overnight accommodation by relatives in addition to a side room where relatives could stay. There was also a play area and toys, books and games available for children attending the hospice.

The service had an onsite mortuary facility. The family support team supported the registration and funeral arrangement processes.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff made reasonable adjustments for patients with a learning disability, such as creating safe and stress-free sensory environments that were appropriate to the patients' needs.

Staff supported patients living with dementia and learning disabilities by using documents which detailed their preferences.

The service had information leaflets available in languages spoken by the patients and local community. Information leaflets were in English but available in different languages or other formats (such as braille, large print or 'easy read' format) which could be printed upon request.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed and staff knew how to access them. The hospice had facilities available for patients living with a disability. All the hospice's services were on the ground floor and services, including the garden areas, were accessible for patients with a wheelchair. The hospice had specialist equipment available, such as equipment to support bariatric (obese) patients.

Hospice services for adults

The day therapy service provided themed sessions which included arts and crafts, singing and music, quizzes, games and activities and exercise and relaxation sessions. Complementary therapy services included reflexology and massage.

The hospice had a prayer and reflection room. Multi-faith pastoral support was available for patients and their relatives.

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. There were processes in place to ensure urgent admission and rapid discharge when needed.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Managers monitored patient moves between services and ensured these were kept to a minimum. The service did not move patients unless there was a clear medical reason or in their best interest.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs and supported patients when they were referred to or transferred between services.

Staff carried out a formal assessment to prioritise patients for admission to the inpatient ward so that patients requiring end of life care would be prioritised for admission over patients requiring respite care or psychological support.

Referrals were discussed directly after the ward handover and all the clinical staff present at handover (doctors, nurses and allied health professionals) were then involved in the discussion about the referrals. Information received on a referral form was considered as per guidance reflecting this policy and documented on a proforma. In the case of obvious or urgent need, discussions took place outside of the morning team meeting in an MDT discussion involving a senior nurse and doctor. Staff told us they reviewed admissions on an individual basis and could articulate when an admission should be declined.

Planned admissions took place between 8am and 7pm. Staff told us that if there was a specific need to admit outside of these times, they would try to accommodate it, such as an urgent need or emergency. This included admissions at weekends.

The average patient waiting time from receipt of referral to admission into the service between January and December 2023 was 5 days for the inpatient ward, however, for urgent admissions there was a 100% compliance with the referral request. Waiting times for the service to provide care to the integrated specialist palliative care team were measured in accordance with the urgency of the referral. Between August and December 2023 for a 2-hour referral the service was 100% compliant with all referrals, for a 24-hour referral the service averaged 81.5% and for 7 working day referrals the service averaged a compliance of 98.2%.

Managers and staff worked to make sure patients did not stay longer than they needed to. The average length of stay between January to December 2023 was 14 days.

Managers also monitored the number of patients whose discharge was delayed and took action to reduce them. The Inpatient ward was a short-stay facility and patients and staff reported there were minimal delayed discharges. Patient

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admissions and discharges were monitored daily through the admissions coordination process and discussed during daily safety huddles to facilitate patient flow. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Managers and staff started planning each patient's discharge as early as possible. We saw evidence of early discharge planning in the patient records we looked at.

Managers worked to keep the number of cancelled appointments in other services to a minimum. Staff told us patients, or their relatives rarely missed counselling or bereavement appointments or day therapy sessions. Managers ensured that patients who did not attend appointments were contacted.

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.

We reviewed the service's policy on compliments, concerns and complaints. We found the policy was up to date, detailed and fit for purpose. We also reviewed the service's up to date duty of candour policy and found it to be in line with national guidelines.

Patients, relatives and carers knew how to complain and raise concerns and the service clearly displayed information on the complaints process in patient areas.

Staff understood the policy on complaints and knew how to handle them. We saw a complaints leaflet was available for patients and their families. Staff knew how to acknowledge complaints and were keen to resolve any issues that were brought to their attention quickly. We saw that patients received feedback from managers after the investigation into their complaint.

The service received 7 formal complaints and 870 compliments between January and December 2023. The main themes from the complaints were issues with communication and complaints about delivery of care. We saw that in the 3 most recent resolved complaints the main issues relating to these themes were: explaining and delivering policies for treatment and access to treatment with clarity, not ensuring clarity by staff about the families perceived experience and providing clear support and information during holiday periods or episodes where the patients health deteriorated faster than expected.

We reviewed the 3 most recent resolved complaints and found these to be managed and responded to well, with the inclusion of patients, families and carers in the resolution process. Additionally, we saw that findings and themes of complaints were shared with staff and actions highlighted through communication bulletins and raised in team meetings.

Is the service well-led?

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

Hospice services for adults

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 hospice was overseen by a board of trustees led by a chairperson. The hospice executive team was led by the chief executive. Other senior posts in the organisational structure included: a director of patient services and clinical quality, a medical director, a director of finances and resources, a director of people and the deputy chief executive director who also held the role of director of income generation and marketing. The senior leadership team was supported by other senior managers and leaders who assisted with education and training, facilities management, research and fundraising among other roles. All roles were embedded within the organisational structure.

All senior managers we spoke with had the relevant skills and abilities to manage the hospice services effectively. They understood the risks to the services and had clear oversight of patient safety, governance and performance issues through daily involvement and quality monitoring. They had effective oversight and accountability over the governance processes used to support the running of the service.

There was compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver sustainable care. Staff we spoke with were complimentary of their leadership.

Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired culture. Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond. As an example, the chief executive demonstrated knowledge of the demographics of the local area and had commenced plans to increase the reach and profile of the hospice to ethnic minority groups living in the region through the development of the new strategic plan for the organisation.

We spoke with the chief executive who told us the board had undergone a renewed vision and strategy for the service which was intended to be a foundation for the future sustainability of the service.

Trustees were encouraged and expected to cast a critical eye and provide the necessary challenge when it was needed. We saw trustees brought a diverse range of skills due to their different cultural and professional backgrounds.

Staff we spoke with told us they understood their reporting structures clearly and described their managers as approachable, visible and providing them with good support. Staff development, research and education were seen as priorities for all staff we spoke with.

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 with supporting plans and objectives which were innovative and achievable. Leaders and staff understood and knew how to apply them and monitor progress.

The strategy and supporting objectives and plans were outreaching and challenging, while remaining achievable. Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrable commitment to system-wide collaboration and leadership.

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The hospice's vision was that "Everyone with an incurable illness has the right to excellent care. This should value and respect their uniqueness and their own choices. People should be enabled to live and die with dignity and with appropriate and compassionate support for themselves and their loved ones". The mission of the service was based on 3 pillars: 1) to enhance the quality of life of adult patients with cancer, progressive neurological conditions and end-stage organ failure for whom curative treatment is no longer possible, 2) to specialise in holistic, multidisciplinary care, focused on the whole person and including family and carers, and 3) to contribute to the education and training of its own and other health and social care professionals and of volunteers with a commitment to research in order to improve the understanding and practice of palliative care.

The vision and mission statement was underpinned by 6 core values that were based on professionalism, collaboration, focus, compassion, trustworthiness and accountability.

The hospice's 5-year strategy and vision (2023-2028) outlined the objectives for the service. The chief executive officer and director of patient services and clinical quality, told us the strategy had been developed with involvement from all relevant stakeholders, including staff, volunteers and other relevant local healthcare services involved with the service. The strategy consisted of 12 strategic priorities that were based on expanding the provision of services to the wider community, providing more advice and support, tackling health inequalities, nurturing talent and staff capabilities, supporting the delivery of care with greater data insight and innovation, increase the brand awareness while campaigning with local and national partners, achieve financial growth and build on the reputation as a centre for excellence in applied research for palliative care..

We heard and saw evidence of how these strategic priorities were underpinned by key performance goals and measurable targets and how each subcommittee of the board was responsible for specific objectives. Progress against key objectives was to be reviewed as part of routine subcommittee meetings and reported to the board of trustees.

The vision, values and strategic objectives were clearly displayed on notice boards across the areas we inspected. They had been cascaded to staff across the services and the staff we spoke with had a good understanding of these.

The strategic objectives were incorporated into the board assurance framework (BAF) and reported to the board of trustees regularly. It was recognised that the strategy aligned to the Care Quality Commission single assessment framework, the ambitions for National Palliative Care and End of Life Partnership and the NHS England Palliative and End of Life Care Statutory Guidance for Integrated Care Boards.

Strategic and service objectives had also been developed for each aspect of the service, for example, inpatient unit, training and human resources. The plan covered all services provided by the hospice and how it intended to expand or develop each service. All leaders were involved in the development of these strategic objectives and felt able to contribute to the future developments of the hospice provision.

We saw evidence of strategy development involving the community, such as regular dialogue with regional stakeholders to ensure the service met the needs of the wider community. The action plan emphasised engagement with stakeholder and partner forums to identify and work on shared agendas and priorities, including exploring opportunities to partner with others, particularly those who support people who were described as under-served.

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.

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Staff we spoke with were highly motivated, patient-focussed and spoke positively about working at the hospice. They told us there was a friendly and open culture.

All staff described leaders as open and approachable and acknowledged the passion dedication and hard work demonstrated by the executive team and senior management to deliver change and improvement. Leaders had an inspiring shared purpose and strove to deliver and motivate staff to succeed.

All staff we spoke with were positive about the changes implemented at the hospice and were able to describe the positive changes that had taken place. Nurses and doctors were keen to share the positive vision of the hospice and emphasise the benefits to patients and those accessing the service. Leaders of the service were open and transparent about the challenges addressed to make improvements and continued to articulate ambitious plans for the future.

Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures within the hospice provided opportunities to do so. Staff we spoke with were aware of the whistleblowing policy and understood how to contact the freedom to speak up guardian if needed. There had not been any significant whistle blower or freedom to speak up concerns raised by the service or received by the Care Quality Commission during the past 12 months.

The service completed staff surveys which were benchmarked against other hospices. In the most recent 2021 staff survey, of the 44 questions asked 33 were at the same level as other hospices, 6 scored better and 5 worse than other hospices. The service used this data to inform the development of their strategy and engage with staff in their personal development plans to address areas identified as worse, such as, feeling overwhelmed and stressed at work, feeling that pay is not comparable to other charities and improving communication between departments and services.

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.

We found that governance processes were in place to ensure patients were safe from risk of harm or potential harm. Leaders of the service had established robust processes to collect, review and improve data and manage risk. Supporting governance committees included clinical governance and development, finance and resources committee, income generation and marketing committee, education and research committee and people and nominations committee.

We reviewed 3 sets of combined governance minutes and found the meetings to be well attended. Agendas were comprehensive, and discussion was detailed. For example, items discussed included a patient story, the Board Assurance Framework (BAF), management accounts, and the risk register.

We saw evidence of shared learning through leadership briefings, team briefings and staff forum notes. Day to day learning was observed during the morning rounds and safety huddles. All learning was shared with the board of trustees and evidenced in the meeting minutes.

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The service produced a yearly quality account in line with requirements set by the health act 2009. Quality accounts are an important way for organisations that provide healthcare commissioned by NHS England or Integrated Care Boards, to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services were measured by looking at patient safety, the effectiveness of treatments patients received, and patient feedback about the care provided.

There was a comprehensive year-round audit plan in place that covered clinical audit, record audit, medicines reconciliation audit, preferred place of death, audit of controlled drugs, safeguarding, tissue viability, oral care to name a few. There were 14 tasks audited throughout the year, on a biannual, quarterly or monthly basis.

The clinical audit programme and associated actions were delivered and monitored by the hospice with final oversight by the clinical governance and development committee. This was a board committee with delegated authority of the board of trustees. The governance and development committee was chaired by a trustee of the board and attended by a minimum of 2 other trustees at each meeting. The Board of Trustees and the governance and development committee could also request additional clinical audits out with those already on the annual audit plan based on triangulated data and intelligence received.

We reviewed other committee and sub-committee meeting minutes and found these to also be comprehensive and supportive of effective governance processes. Medicines management, mortality and morbidity and the education and research committee meeting minutes were comprehensive, accountable and had clear and established agenda items that promoted excellence in the service.

Management of risk, issues and performance

Leaders and teams demonstrated commitment to best practice performance and risk management systems and processes. They identified and escalated relevant risks and issues and identified actions to reduce their impact effectively and in a timely manner. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There was a demonstrated commitment to best practice performance and risk management systems and processes. The organisation reviewed how they functioned and ensured that staff at all levels had the skills and knowledge to use those systems and processes effectively. Problems were identified and addressed quickly and openly.

Leaders of the service understood risk and could identify organisational or clinical risks. The service had an up to date risk management policy to enable individuals and the hospice to deal competently with all key risks, thereby providing more confidence that personal and organisational objectives would be achieved and that statutory and regulatory requirements placed upon the hospice were met. This was supported by a dynamic risk register, which was a live document, reviewed regularly and updated as new risks were identified, changed, grew or receded.

The service assured organisational risks and oversight were managed in line with the services vision and strategy. The BAF was introduced in March 2023 by the trustees with the objective of bringing together in one place all the relevant information on risk related to delivering the charity's objectives. It sets out 12 risks for the board, based on an analysis of the evolving risks in the charity risk register. The BAF was an evolving and live document where key matters, risk heat map and descriptions of the board risks were outlined clearly and in an accountable manner. The flexibility and oversight of the BAF allowed for a macro management of risk of the organisation which could effectively filter through governance structures to impact and improve the delivery of quality care for patients.

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The service had comprehensive policies to manage major incident, disaster recovery and business continuity policies. The plan set out the roles of those who may be involved in managing an interruption event, and the subsequent business continuity and recovery phases.

We reviewed governance meeting minutes and found that the meetings were well attended, were quorate, and that comprehensive discussion was held relating to the quality and safety dashboard, and audit outcomes. This ensured risks, service performance and issues were dealt with and managed in accordance with regulatory standards.

We saw incidents were reviewed through the electronic system and lessons learned and improvement ideas were shared across all disciplines.

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.

Senior managers collated and analysed information on performance to look for improvements and routine performance reports were in place detailing performance against key performance indicators.

There were systems in place for the safe storage, circulation and management of electronic and paper-based records, such as patient records, audit records and meeting minutes. Patient records were accessible for staff and could be easily retrieved. Electronic records were stored on computers with controlled access.

Staff completed general data protection regulation and confidentiality training as part of their mandatory training. The director of clinical services was information governance lead and was responsible for reporting to the Information Commissioner's Office. The director of patient services and clinical quality confirmed there had been no reportable data breaches during the past 12 months.

Staff could access information, such as policies and procedures in paper and electronic format. The policies we looked at were version-controlled, up to date and had periodic review dates.

Engagement

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

The hospice routinely engaged with patients and their relatives to gain feedback from them. This was done informally and formally through participation in patient surveys and through patient and relatives focus groups. We reviewed feedback and saw that it was overwhelmingly positive.

There was a constant presence of the senior leadership team, as well as walk arounds by the board and trustees to understand and see and hear first accounts of the care being provided. The most recent staff survey highlighted this as a positive and staff we spoke with were complimentary of the support and engagement with the senior leadership team.

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Staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings and took part in daily huddles across the areas we inspected. The senior managers also engaged with staff through newsletters, briefs and through other general information and correspondence that was displayed on notice boards and in staff rooms.

The hospice carried out routine staff surveys to gain feedback from various staff groups about their experiences. The findings from staff and volunteer surveys carried out over the past 12 months had been analysed to look identify and implement improvements.

The service held staff away days and a team building event. This was said to be an opportunity for all staff to spend time together to learn about each other and the different roles at the hospice. It also aimed to share ideas for growth and development of the hospice and to support each other in the quality improvement journey across all the services and activities. Output from the group work was used to inform a review of hospice strategic objectives.

There was a staff health and wellbeing service with an employee assistance programme in place in addition to standard occupational health services provided to all hospice staff through a local hospital trust. This provided staff with free resources and access to a confidential helpline and fast track counselling sessions.

We saw evidence of routine formal and informal engagement with stakeholders, commissioners and other healthcare providers as part of local and regional integrated care systems and regional palliative care collaboratives. The hospice saw these relationships as very important strategic partnerships and held regular meetings and joint ventures with the local NHS trust and university.

The hospice also held regular public engagement events attended by members of the general public and local community representatives to promote the service. We heard how community organisations worked with the hospice out of hours and weekends, complementing the service's provisions with mental health support, advocating support for transitional patients from children to adulthood in palliative services and collaborating with smaller hospices to support rural care.

The hospice also engaged regularly with volunteers and patrons to the service. The mix of high-profile patrons and community leaders was seen as a key to delivering better, more equitable services to the local community.

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, entrepreneurialism and participation in research. Staff were actively participating in research and improvement projects.

The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. Since the last inspection, there had been a change to the executive team, senior leadership team and board of trustees.

There was a fully embedded and systematic approach to improvement, which made consistent use of a recognised improvement methodology. Improvement was seen as the way to deal with performance and for the organisation to

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learn. Improvement methods and skills were available and used across the service, and staff were empowered to lead and deliver change. During the inspection we saw evidence that quality improvement projects were being used to support continuous improvement in patient safety, the effectiveness of the service, the staff approach to delivering care, how responsive the service was and the overall impact of the new leadership team.

We saw examples of learning from incidents and complaints and were assured that shared learning occurred on a frequent basis. We saw drive and ambition within the executive, leadership and staff teams to continually learn and improve the service.

The organisation was driven to push cultural and ethnic beliefs regarding end of life care. They were actively looking at methodology and engagement strategies to address and improve access to care for diverse ethnic communities. This included the introduction of roles, such as the wellbeing coordinator, liaising with south Asian network and learning from findings from public health. Additionally, the service had bereavement hubs within the community and supported volunteer schemes, such as the compassionate neighbours scheme. These schemes offered companionship, emotional support and extended their help to provide practical support to stay connected with family and friends and do small household chores.

The service had a Centre for Excellence training centre. This location was a professional development centre with clinical training suites and research facility. Research themes were focused on personalised care regarding decision making and communication, symptom management in advance illness and palliative care for older people. An example of recent research being undertaken at the centre included the participation in the CHELsea II nutritional support for end of life care. The service was also developing the Thinking Ahead study. This 3-year study was funded by the National Institute of Health Research to provide a better understanding of the needs of ethnically diverse patients and their families when they become very ill.

The service was proactive and ambitious in their research and delivery of training in end of life care. LOROS worked in partnership with higher and further education providers to supply education, training and support to over 2,165 health and social care professionals every year.

The service provided specialist care for people who were diagnosed with motor neurone disease (MND). The service and specialist staff worked closely with the MND association in providing and developing advanced care guidelines.

The service was innovative in its medical outpatient care provision. Services provided by the medical outpatient clinic included treatments, such as infusions (zoledronic acid) which could be facilitated at the request of the doctor. This allowed outpatients to have timely access to key therapies and having a place of choice for their procedures.

The hospice also had a dedicated lymphoedema service. The nurse-led lymphoedema service provided specialist care for patients with lymphoedema caused by cancer or cancer treatments and for palliative patients known to other LOROS services