

The Rotherham Hospice Trust

The Rotherham Hospice

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?	Requires Improvement 
Is the service effective?	Good 
Is the service caring?	Good 
Is the service responsive?	Requires Improvement 
Is the service well-led?	Requires Improvement 

Summary of findings

Overall summary

The Rotherham Hospice is purpose built and offers a range of services for the people in area of Rotherham. It is situated on the outskirts of Rotherham town centre and has good transport links.

The hospice has a 14 bed inpatient unit. All bedrooms are single occupancy with ensuite facilities.

The hospice provides a day hospice service and a day therapy and treatment service. The day hospice is open six days a week.

The purpose of the day hospice is to offer support and advice to people, a range of activities, and incorporates therapies such as physiotherapy and occupational therapy alongside complementary therapies and emotional support.

The day therapy and treatment service offers day treatments, such as blood transfusions, to improve symptom control to aid the feeling of "well-being" to enable people to remain independent for as long as possible.

Health and well-being services are delivered in day hospice. The service includes a 12 week group programme focusing on key issues that need to be addressed to aid well-being. Advice is given on areas such as staying active, diet and pain management.

The hospice has counselling, bereavement and psychology services which are available to people, children and their families. People can be seen individually or with their family.

Rotherham Hospice has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Day-to-day operation of the hospice is delegated by the Board of Trustees to the Chief Executive Officer (CEO). The CEO discharges responsibilities through the Hospice Executive Team.

Specialist palliative care practitioners provide medical cover together with two part time consultants in palliative medicine. 24 hour cover by the medical team is provided.

As part of Rotherham Hospice community team the 'Hospice at Home' team support people and their families in their home 24 hours a day. There is also an advice line available to people, their families and professionals 24 hours a day. The line is operated by a qualified specialist nurse who provide advice on the phone or by visiting the person with any concerns or care needs.

Our last inspection at Rotherham Hospice took place in July 2014. Rotherham Hospice was found to be meeting the requirements of the regulations we inspected at that time.

This inspection took place on 15 and 17 August 2016. The inspection on 15 August 2015 was unannounced. This meant staff at the hospice did not know we were coming. On 15 August 2016 nine beds on the in-patient unit were occupied and the 'Hospice at Home' team were supporting 23 people.

We found suitable arrangements were in place to help safeguard people from abuse. Staff knew what to do if an allegation of abuse was made to them or if they suspected that abuse had occurred.

The service was not consistently following safe practice surrounding medicines management.

We found people were cared for by sufficient numbers of suitably skilled, competent and experienced staff who were safely recruited. Staff received the essential training and support necessary to enable them to do their job effectively and care for people safely.

People were supported to maintain a nutritious diet at the service and people told us about the high quality of the food. There was a choice of menu, drinks and snacks provided.

Staff worked within the principles of the Mental Capacity Act (MCA) where appropriate. People had choices about their care and their consent was sought by staff although this consent was not always clearly recorded.

People, who used the service, and their families, told us that they were supported by caring, kind staff and treated with respect.

Some care plans did not fully reflect the person's needs. The care plans did not contain sufficient information to identify the person had been fully involved in the initial and ongoing assessment process's and so were not person centred.

There was a complaints process in place. We found the service had a robust process in place to enable them to respond to people and/or their representative's concerns, investigate them and take action to address their concerns.

We received positive comments regarding the overall management of Rotherham Hospice from staff, other care professionals, relatives and people who used the service.

There were quality assurance systems and audits in place. However, the systems and audits were not always effective in monitoring performance.

The registered provider was notifying the Care Quality Commission appropriately of notifiable events and incidents.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

Some areas of the service were not safe.

The service was not consistently following safe practice surrounding medicines management.

Risk assessments were in place to ensure people's health and safety although some assessments were incomplete.

The required employment checks had been carried out when new staff and volunteers were recruited to ensure they were suitable to work with vulnerable people.

There were enough staff to support people and keep them safe.

The premises and equipment were maintained to a high standard.

Is the service effective?

Good ●

The service was effective.

Staff told us they were supported through induction, regular on-going training, supervision and appraisal.

Staff worked within the principles of the Mental Capacity Act (MCA) where appropriate. People had choices about their care and their consent was sought by staff although this consent was not always clearly recorded.

People were provided with a choice of suitable nutritious food and drink to ensure their health care needs were met.

People were supported to maintain good health and were referred to health care professionals when needed.

Is the service caring?

Good ●

The service was caring.

People spoke highly of the kindness and caring attitude of the staff. People were cared for with kindness, dignity and respect.

People were supported at the end of their life to have a comfortable, dignified and pain-free death.

Visitors were made welcome and the staff recognised and considered the importance of caring for the needs of all family members and friends.

Is the service responsive?

The service was not always responsive.

Some care plans did not fully reflect the person's needs. The care plans did not contain sufficient information to identify the person had been fully involved in the initial and ongoing assessment processes and so were not person centred.

People were encouraged to be involved in making choices regarding their care and treatment.

A copy of the complaints procedure was available and complaints records were maintained.

Requires Improvement 

Is the service well-led?

The service was not well led in some areas.

The home had a registered manager in post.

We received positive comments regarding the overall management of the hospice from staff, relatives and people who used the service.

There were quality assurance systems and audits in place. However, the systems and audits were not always effective in monitoring performance.

The service was actively involved in building local community links, took part in project work and close working with other hospices and organisations at regional and national level.

Requires Improvement 

The Rotherham Hospice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was carried out to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was carried out on 15 and 17 August 2016. The inspection on 15 August 2016 was unannounced. We gave short notice to the registered provider of our visit on 17 August 2016 because we needed to be sure that key people would be available during our inspection visit. The inspection team consisted of two inspectors, a pharmacist inspector and a specialist advisor in palliative care.

Prior to our inspection, we spoke with stakeholders, including the local NHS Clinical Commissioning Group. We sent out questionnaires to people and their families, staff and external care professionals who supported people who had used Rotherham Hospice services. This information was reviewed and used to assist with our inspection and the findings are included throughout the report.

Before our inspection, we reviewed the information we held about the hospice. This included correspondence we had received about the service and notifications submitted by the service. The service was not asked to complete a provider information return (PIR) for this inspection because we had changed the inspection date. A PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spent time observing the care and support being offered to people. We spoke with three people on the in-patient unit, three people on the day unit and four family members or visitors to the hospice.

Over the two days of inspection we spoke with 24 staff from the inpatient unit, day unit, and hospice at home team. Staff we spoke with included the registered manager, nursing and medical and social care staff, student nurses on placement at the hospice and health care assistants. We also spoke with the Chief Executive Officer, Chairman of the Board of Trustees, administration staff, catering and housekeeping staff and people who worked as volunteers at the hospice.

During our inspection we looked at the systems in place for managing medicines; spoke with four members of medical and nursing staff involved with prescribing and giving people their medicines, looked at six people's medicines charts and spoke with three people using the service in relation to medicines management.

We spent time looking at records, which included three people's care records, six staff records and other records relating to the management of the hospice such as training records and quality assurance audits and reports.

Is the service safe?

Our findings

Comments made by people who used the service demonstrated to us they felt safe. Their comments included, "I feel safe and comfortable here" and "Feel safe and sound."

We looked at the arrangements at the hospice for safeguarding vulnerable adults and children from the risk of abuse. There was information within the public areas about safeguarding, and staff we spoke with had a good knowledge of this topic. A member of nursing staff with whom we spoke could describe the steps they had taken recently in relation to alerting safeguarding concerns to the local authority. They understood the processes and participated in safeguarding meetings with the local authority to ensure appropriate information was shared in order to protect the vulnerable individual. Another staff member told us about another safeguarding concern and described the appropriate action they had taken, including making referrals to specialist support. This meant that vulnerable adults and children were safeguarded from harm by the provider.

The provider had a system in place whereby all safeguarding concerns were documented and reviewed, regardless of whether they were considered to require an alert to the local authority. This meant that patterns and themes could emerge and very minor concerns were not missed. Safeguarding incidents and alerts were reviewed within clinical governance and senior management meetings, again so that any recurring themes could be identified, and to ensure that senior managers and the board of trustees understood when safeguarding issues were being dealt with by the service.

People were protected and their freedom supported and respected because the risk of possible harm was identified and managed. Risk assessments had been carried out to identify and manage people's individual risks. The care records included risk assessments including falls, nutrition, mobility and tissue viability. There were some risk assessments observed in people's care records which were not all fully completed. These included Waterlow score (to assess tissue viability risk), fall prevention assessment and bed rails risk assessment.

Bed rails risk assessments were in place for people with bedrails, signed by nursing staff but not by people. The nurses said people were never asked to sign these risk assessments and there was not space on the form for them to do so. The use of bed rails is a form of restraint and data shows that bed rails sometimes don't prevent falls and can introduce other risks such as rolling over the top of the rail or climbing over the rail thus introducing a risk of the person falling from a greater height. It is therefore important that people understand these risks and the restraint aspect of rails and consent to their use.

The registered manager said people signed a generic consent form for care and treatment but said they would look at individual risk assessment forms in use to see what improvements could be made for compliance of use.

All the staff interviewed could describe the incident and accident procedures and one nurse gave an example of the process that had been followed when someone fell in the hospice. They were clear about the

reporting process and documentation completed. Staff we spoke with said the family would be informed following any incident or accident involving a person at the hospice and mentioned Duty of Candour (Requirement that providers must be open and honest with people and other 'relevant persons' if things go wrong with care and treatment).

The hospice had specialist laser equipment in place on the inpatient unit to monitor patient movements and prevent falls.

We looked to see what systems were in place in the event of an emergency. We saw personal emergency evacuation plans (PEEPs) had been developed for the people who used the service. These were updated daily and kept centrally. This information assists the emergency services in the event of an emergency arising, helping to keep people safe.

Fire equipment was observed in both stairways including a portable mattress to support evacuation of bed bound/ less mobile people if required. Oxygen cylinders and concentrators were stored in a locked cupboard to minimise risk.

Inspection of the staff rosters and discussions with staff and relatives of people who used the service showed there were sufficient, suitably qualified and competent staff available to meet people's needs.

People and visitors said, "There are always plenty of staff about and are there when you need them" and "The volunteers are really good, they do so much."

The hospice employed a range of health and social care staff to meet people's physical, psychological and social needs. In-patient, day care and hospice at home care was provided by a specialist team of doctors, nurses, healthcare assistants and nursing auxiliaries, therapists and social workers. They were supported by housekeeping and maintenance teams, administration staff and volunteers.

The registered manager had systems in place including a 'specific dependency tool' to calculate how many staff were required to provide appropriate levels of care and support for people. The registered manager said they had sufficient staff to increase staffing levels at short notice should people's increasing needs require this. The registered manager gave an example where three staff were required to provide care for one person due to the person's complex physical needs. The registered manager said they were able to meet this person's needs by increasing staffing numbers over a particular period of time. Staff working within all areas of the service told us staffing levels were appropriate for people's care needs. Staff told us, "Yes, I have to say we are really well staffed" and "Staffing levels are really good, but that gives us time to care."

Medical staff said there was a team of four palliative care doctors ensuring 24/7 medical support to services across the local area covering the hospice, hospital and community/ hospice at home services. This included an out of hours/ on call telephone advisory support.

A lead palliative care consultant for the hospice is based in the hospice four days/ 30 hours a week and works flexibly in the hospital and community as and when required.

The hospice medical team provided 7 day a week medical cover on site from 9am to 7pm on weekdays and 9am to 5pm on weekends. The hospice also provided in house out of hours on call medical service 24 hours a day. Cover was also provided for 2nd level consultant on call, in partnership with Barnsley and Doncaster. This meant the hospice had 24 hour in house medical support which provided ongoing care and supervision

to people and staff.

Volunteers, managed by a volunteer coordinator, were observed working in the hospice in a variety of areas including helping in day care with activities, managing the front desk, delivering complementary therapies (some are trained in hand and foot massage/ therapeutic touch). We saw volunteer drivers bring people in and out of day care or other services.

We reviewed staff recruitment records for six staff members. The records contained a range of information including the following: application, references including one from the applicant's most recent employer, employment contract and Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service (DBS) provides criminal records checking and barring functions to help employers make safer recruitment decisions. We also saw evidence where applicable, that the nurse's Nursing and Midwifery Council (NMC) registration had been checked. This told us that people were cared for by suitably qualified staff that were of good character.

We looked at the systems in place for medicines management. We assessed six prescription records and spoke with four staff including medical and nursing staff.

We found there was a medicines policy in place at the hospice. This policy was available to all staff and covered all aspects of medicines management.

People we spoke with told us they received their medicines in a timely manner, including pain relief, and that doctors and nurses discussed medication changes with them so they remained informed about their treatment.

Medicines and intravenous fluids were stored securely with access restricted to authorised staff. There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and we saw evidence of routine balance checks.

Unwanted medicines were disposed of in accordance with waste regulations.

We found evidence the service was not consistently following safe practice around medicines management.

We found 12 opened bottles of medicines in solution form in a cupboard in the medicines storage room. The medicines included antibiotics, medicines used to manage diabetes and medicines used to control nausea and vomiting. There was no opening date identified on 11 of the 12 bottles and none contained the name of the person they were prescribed for or administered to which made tracking and auditing of the medicines very difficult. Each bottle contained different timescales, but all stated that contents should be discarded between 28 days and 6 months after opening. Because there were no dates identified as to when the bottles were opened staff had no way of tracking if the medicine had past the expiry date. Once medicines expire they can begin breaking down which can make them less effective. Some drugs can actually change chemical composition and become toxic but most just lose effectiveness.

We found one box of medicines was 14 days out of date. A staff nurse immediately disposed of all medicines we identified as out of date.

Medicines requiring refrigeration were stored securely, however one of the fridges did not have a thermometer capable of taking maximum and minimum readings. The senior nurse took action to rectify

this during our visit. A new thermometer was fitted to the fridge by the end of our inspection.

There was no written evidence of the action that was taken by staff when temperatures fell outside of the recommended range for storing medicines.

We saw three instances in July 2016 where temperatures greater than eight Celsius had been logged and staff had not recorded the action taken, a senior nurse told us they were also unaware there had been a problem. The registered manager later told us how the medicines were moved to another fridge. There were some gaps in temperature records; no records had been made for nine days in July 2016 for one of the fridges. Staff said this was because the fridge was not in use at this time.

Medicines were given as prescribed, and administration records were completed accurately by nursing staff. There was a lack of information to enable staff to safely administer 'when required' medicines. For example, all of the prescriptions we reviewed lacked maximum doses and minimum dose intervals. This increases the risk of a person receiving too much of a medicine, or receiving a further dose without a safe gap. We discussed this with senior medical staff who assured us action would be taken to improve the prescribing of these medicines. Medical staff checked (reconciled) patients' medicines on admission to the service by speaking with them and their GP.

Medicines were not always being managed in a safe way. We found this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Blank prescription pads were stored securely and records were maintained in accordance with national guidance.

Staff told us there was a medicines management training programme in place and regular observation in practice was undertaken to ensure staff were performing to the necessary standards. We saw records of this training and the competency checks the senior nursing staff had undertaken.

There was a system in place for responding to medicines safety alerts. There was a designated senior staff member who was responsible for receiving and disseminating such alerts. The staff member told us that whenever safety alerts were received they were shared with all relevant staff, who were then required to confirm what action had been taken, or alternatively to confirm that no action was required. This was a failsafe system to ensure that all safety alerts were considered and evidence was available showing where action had been taken.

We saw infection prevention and control policies and procedures were in place. We were told there was a designated lead person who was responsible for the infection prevention and control management. Hand-wash sinks with liquid soap and paper towels were available in all clinical areas, bedrooms, bathrooms, sluices, toilets, the kitchen and the laundry. Alcohol hand-gels were in place at reception and throughout the corridors. Good hand hygiene helps prevent the spread of infection.

The hospice was very clean, organised and uncluttered. Staff wore appropriate personal protective equipment (PPE) which was in ample supply. These measures protected people from the risks of acquiring an infection while in the service as much as possible to keep them safe.

Is the service effective?

Our findings

People staying at the hospice said they thought staff had the knowledge and skills to support them. People said, "Staff are very good and know what they are doing." People used words including "approachable" and "helpful" to describe the hospice team.

Staff had undertaken appropriate training to ensure they had the skills and competencies to meet people's needs.

New staff undertook a comprehensive induction programme which included essential training and the shadowing of experienced care staff. Staff said, "When I started at the hospice I felt well inducted and have attended relevant training in the months that followed."

Staff said they had access to an annual two day mandatory training course. These were run regularly and attendance for the staff was allocated on the duty rota. All members of the hospice team attended these training days. The course covered areas such as safeguarding (adult and children), moving and handling, health and safety, fire training/ safety and cardio pulmonary resuscitation.

Staff said they had access to internal and external courses to support their professional development or clinical training/ needs. Staff told us the training they had attended included, basic principles of palliative care, a tracheostomy study day held by a local NHS Trust, internal training on dementia care, an in house nutrition course and an external two day course on loss and bereavement. Some staff said they had been supported to undertake degree courses in palliative care.

Staff said the Clinical Nurse Specialist or those in the team with an interest or expertise often deliver internal training sessions and had access to on-line training, for example in the use of the syringe drivers.

We sampled a selection of six personnel /training files (of different grades; nurses, HCAs and one admin/reception). These files identified regular training was available and took place for staff.

The registered manager said volunteers were highly valued as a part of the hospice team and were trained to support their various roles. For example the volunteer drivers had oxygen, moving and handling and safeguarding training.

Staff spoke positively of the supervision, appraisal and support provided by their peers and managers and told us this enabled them to carry out their roles effectively. Supervision is an accountable, two-way process, which supports, motivates and enables the development of good practice for individual staff members. Appraisal is a process involving the review of a staff member's performance and improvement over a period of time, usually annually.

Staff said they received annual appraisal but two staff said they didn't receive supervision frequently. We checked a sample of staff files which confirmed that staff did receive annual appraisal and supervision,

although in two of the files we checked we noted that supervision had not taken place at the frequency required by the provider's own policy.

Staff said, "I feel supported at all times," "We have best practice meetings every six weeks or so, they are very good and anyone can attend" and "I feel supported, I would be happy to go to members of the management team for support or advice if necessary."

One nurse we spoke with said they valued attending Schwartz Rounds led by one of the doctors, which were open for anyone at the hospice to attend. These were case study based and enabled some reflection on care. Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. The purpose of Rounds is to understand the challenges and rewards that are intrinsic to providing care, not to solve problems or to focus on the clinical aspects of patient care.

Medical and nursing staff said there was a weekly Borough wide Multi Disciplinary Team (MDT) meeting and also a daily hospice MDT held to discuss ongoing issues relating to people. The team also attended a variety of meetings in organisations outside the hospice. Staff we spoke with said they attended ward meetings.

The registered manager said volunteers working for the hospice were managed by a volunteer coordinator and departmental leads who ensured they received handovers, supervision and time for reflective practice.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes, hospices and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our visit, there had been no applications to place a restriction on a person's liberty.

Staff had received training in the Mental Capacity Act and the Deprivation of Liberty Safeguards. One staff member was designated to oversee this area and they had a good knowledge in relation to their responsibilities. We spoke with another staff member about how they would judge whether a person had capacity. They could describe in depth the tools available to them, and what steps they could take if they were unsure whether a person had the capacity to give consent to their care and treatment.

The hospice's 'patient safety and clinical risk management group' took place on a fortnightly basis, and oversaw all DoLS applications and outcomes.

People had choices about their care and their consent was sought by staff although this consent was not always clearly recorded.

Do Not Attempt Cardiopulmonary Resuscitation (DNA CPR) were in place in the three sets of people's care records we checked. All were written in black, with reason for DNA CPR and signed and dated by a doctor.

One DNA CPR recorded that resuscitation had been discussed with the person's family, but not the person. It was not recorded anywhere in the person's records they lacked capacity.

When asked about the DNA CPRs, medical staff said they often have conversations with people allowing them to explore/ discuss their wishes at end of life and they do not always openly discuss resuscitation.

We checked to see if people were provided with a choice of suitable and nutritious food to ensure their health care needs were met.

People's nutritional needs were identified on admission to the hospice and discussed with them and their family. Dietary advice was available from a community dietician on request.

People we spoke with said, "The food is very nice and there is lots of choice so I can always find something I want to eat," "I am not eating much but the catering team have a good daily menu with choices on it, if I didn't like anything staff would do their best to find something I can enjoy," "Last week the cook made salmon and cucumber sandwiches on my request" and "My [relative] was visiting and the catering staff cooked them a full English breakfast."

A discussion with the cook showed they worked closely with the nursing staff to ensure the variety and content of the meals provided was appropriate for the people who used the service. The cook was knowledgeable about any special diets that people needed and was said they were updated daily on people's dietary needs. The cook said if people didn't like the choice of meal on the menu they could always have something else from the food stocks. We were told that food was always available out of hours.

We saw lunch being served to people. There were pleasant interactions from the staff towards people. It was not a rushed event. Volunteers served the meals and they wore protective aprons and offered each patient a choice of meal.

External health professionals spoke highly of the health professionals involved in people's care at The Rotherham Hospice. Comments received included, "I have always had very good feedback from our patients who attend this service and cannot remember having any complaints about the hospice at all," "Feedback I have received from patients and their families is always very positive, overall the hospice staff provide an excellent service" and "Over the years I've only received positive feedback from patients and carers/relatives. The hospice seems pro-active in relation to education."

The nurses and medical staff we spoke with said they link closely with a number of other external organisations and services including, Rotherham Hospital and acute services, other local hospices (Barnsley and Doncaster Hospices and medical teams have shared medical on call rota), district nursing teams, GPs, Health and Social care teams, safeguarding teams, community therapy (OT and Physiotherapy), tissue viability team, hospital chaplaincy/ spiritual support organisations/ local churches and community dieticians.

Hospice staff said translating services either face to face or via telephone were available for people who needed assistance with translation of language. One of the nurses gave an example how they had recently used this service for a person and their family.

The Clinical Nurse Specialist attended Gold Standard Framework (GSF) meetings and Long Term Condition (LTC) meetings at local GP surgeries.

The National Gold Standards Framework (GSF) Centre in End of Life Care is the national training and coordinating centre for all GSF programmes, enabling staff to provide a gold standard of care for people nearing the end of life. GSF aim is to improve the quality, coordination and organisation of care leading to better patient outcomes in line with their needs and preferences and greater cost efficiency through reducing hospitalisation.

The hospice team also have representatives on external working groups for example one of the team sits on the local NHS Foundation Trust operations group.

A range of hospice facilities were seen appropriately decorated, equipped and furnished for delivery of palliative, end of life care & family/ carer support. There were 14 individual bedrooms, all with en-suite facilities and tracked ceiling hoists to support people's safe movement around the room. There was adequate space in most bedrooms for relatives to stay with open access for family members to visit the hospice.

There was a family room with kitchen/ fridge and a selection of toys/ games for children. A laundry room was available for people to wash their own items (hospice laundry is sent out to a commercial laundry service) and a kitchen and dining room area where all people (day and inpatients) and their relatives can eat.

In the day unit there was an activity/ craft area, managed by activity co-ordinators and volunteers, for people to use, with a large table, which was used for craft and various other activities.

We saw people and their families accessing a spacious outdoor balcony and well managed gardens. Within the beautifully managed gardens which surround the hospice there was a 'tree of life' sculpture where 'leaf memorials' can be hung by families/ friends.

Is the service caring?

Our findings

People and their family and friends spoke very highly of the kindness and caring attitude of the staff. Comments included, "The care is fantastic," "Care is second to none," "They are angels" and "Nothing is too much trouble for them."

Family and friends also praised the staff of the hospice and commented on their caring attitude and the kindness and the support staff offered them. Feedback from relatives included, "The care is without a doubt the most comforting at such difficult times and is outstanding," "The care we received was outstanding and supported the whole family," "Staff have helped make an unbearable time more bearable" and "A lovely, caring experience."

The hospice inpatient unit had a relaxed, calm environment. Staff were observed around the hospice facilities. They were interacting and conversing with patients and visitors in a relaxed, courteous, polite & respectful manner. There were smiles and offers of help. Staff appeared to know people well and we saw people responded positively to this. The team were seen to be mindful about people's privacy and dignity. For example staff were observed asking people if they would be happy to speak to the inspection team or to receive visitors. Curtains were seen pulled around some people who were in bed, but chose to have their doors open, to maintain their privacy.

One person had just had a bed bath and looked well cared for in clean nightclothes with hair brushed. They were being nursed on an air mattress, with continuous oxygen. They said, "I just wanted to be kept comfortable and I am."

We saw people could choose where and how to spend their time. We saw people using the various lounge spaces, cafeteria or outdoor gardens around the hospice. People said, "I like my own space, I like to go for a walk around the gardens. They are beautiful."

People and their families said the privacy of people was always respected. Comments we received included, "He really loves going (to the day centre) and says 'They (staff) are very good there,' Staff always respect his wishes," "The hospice team were very good at respecting her privacy and they always came and asked her if she wants to see visitors when they arrived," "Staff always knock on my door and wait for me to call before entering the room" and "The care and respect shown to me and my family was excellent."

People gave permission for their care records and charts to be observed. Standardised Care plans were in place, which reflected some of the people's care needs as described by themselves and their families. These included standardised care plans for end of life which covered a range of general end of life care wishes and requirements.

The hospice team were able to demonstrate that they would 'go out of their way' to be responsive to meet people's needs. For example the registered manager described the care they had provided at the hospice of a young person with a baby. The person had really wanted to go home to die and the hospice team

provided community/ hospice at home care ahead of being awarded Continuing Health Care (CHC) funding, as this was taking too long to process. The person was able to die at home with their family around them.

This case also demonstrated effective multidisciplinary working as the hospice team and palliative care consultant, worked with the GP, district nurses (who supported wound care) and domiciliary carers to provide the required package of care.

We spoke with staff about how they recognised, and supported, people's differing cultural needs. One staff member described how this was taken into consideration when first assessing a person before they began to use the service, and could describe sensitively what steps they needed to take when addressing people's cultural needs.

The hospice had a chaplain who was available to talk with people and their friends and relatives. The chaplain was able to arrange visits from representatives of other faiths if required by people using the service. People's own vicar/spiritual leader would come in to take communion/ perform religious ceremonies if a patient requested this. A priest from the local parish was visiting people on the day unit on the day of our inspection.

There was a counselling service for people and their families which was based at the hospice.

Staff told us how they supported families at the time of death and after; this included families or carers being able to stay with their loved one as long as they wished.

Bereavement support was available to anyone whose family or friend was previously or currently being cared for by Rotherham Hospice.

Family support/ bereavement support services were offered by trained nursing staff and volunteers for all age groups. These included the 'Sunbeam' children's bereavement group; The adult bereavement support group which runs weekly on Monday evenings. There was also a carers drop session from 1-5pm on Wednesdays and the group run their own self-managed session immediately afterwards from 5-7pm.

Hospice facilities observed were appropriately equipped/ furnished for delivery of person/ family centred palliative and End of Life care. There was space in most bedrooms for relatives to stay with open access for family members to the hospice. People's families told us they could visit at any time and were always made to feel welcome by the staff. There was an open visiting policy, meaning that inpatients could receive visitors at any time. Sleeping facilities were available for visitors, and the hospice also had facilities for welcoming visiting children and babies. Pets could also be taken to visit people.

There were quiet private spaces where people or families could get away and take time out to grieve or reflect. There was a large reflection room, a quiet sitting area and balcony on the inpatient unit and two small sitting rooms for family/ patient use. Staff told us the sitting rooms were also used for one to one work such as family/ bereavement support with family members.

Is the service responsive?

Our findings

People we spoke with said they were involved in discussions about their care and staff listened and acted on their views. People were all very positive and complementary about the services they received. People we spoke with had a clear understanding of the reasons for their admission. They said they were receiving good information from the hospice team and were very happy with the care.

People and their relatives told us that the way staff responded to their needs was, "Excellent" and "Second to none."

A care professional we contacted prior to our inspection said, "Whenever I need some guidance or information the hospice doctors and nurses respond and are very helpful."

On the days of inspection we did not hear call bells ringing for any length of time. We observed staff being attentive to people and responding to their requests for assistance in a timely manner.

We looked at the care records belonging to three people on the inpatient unit and were provided with an oversight of the care records for people receiving care from the hospice at home team.

The care plans we checked for people on the inpatient unit (IPU) did not fully reflect the person's needs. The care plans did not contain sufficient information to identify the person had been fully involved in the initial and ongoing assessment process's and so were not person centred.

People's care and medical records on the IPU were kept in accessible uniform files, red file for care plans/ clinical risk assessments / charts and blue file for medical and nursing assessments and Multi-Disciplinary Team (MDT) notes and correspondence.

The records observed were legible, dated and signed and written in black ink. There was a staff signature record sheet at the front of the notes folders.

People we spoke with were informed and could describe their care, but care plans did not always accurately reflect their care needs. Standardised printed care plans were used with very limited space for individual adaptation, which did not demonstrate person centred practice. There was evidence staff had not always responded to a person's assessed needs.

There were no specific individualised care plans in place to detail actions/ care management as a result of identified high clinical risks for example pressure area care for pressure areas assessed as high risk or dietary support required by the patient.

We found the 'All about me' documents were blank in two care plans we checked. These are documents that inform staff about the person's likes/dislikes, life histories etc. and can help plan person centred care. When we asked the nursing team about why the documents were blank they said they were waiting for the activity

volunteers to complete this paperwork.

All the care plans we looked at lacked detail about care management. For example a care plan for a person with specific urinary drains in place was written on a standard 'wound drain' care plan and did not record specific management of the drain sites, types of bags used, fluid balance monitoring or the patient's ability to self-manage.

Another person, who had been in the hospice for a week as an inpatient, had a peripherally inserted central catheters or 'PIC' line in situ, which needed weekly flushes and dressing change. There was no mention of the PIC line in any of the person's records/ care plans or assessments. When asked, members of the IPU team could not find any mention of this line in any of the care plans, assessments or MDT records. The person told us the line was usually flushed weekly but it had not been flushed, or the dressing changed, for a month. On the second day of inspection we saw the dressing around the site had been changed and the line flushed.

Another person was on continuous piped oxygen delivered via nasal cannula. There was a standardised End of Life (EoL) care plan in place which mentioned that a person may need oxygen therapy, but no specific care plan describing care management of continuous oxygen/ nasal cannula and the oxygen was not prescribed on the medication chart/ record.

There was a pain assessment tool included in the assessment paperwork in the blue folders, but this had not completed in any of the three sets of notes we checked. Two people we spoke with said they did not have any pain. However, another person we spoke with had described pain, on admission, this was recorded in the initial assessment, but the pain tool had not been completed.

There were a number of appropriate clinical risk assessments in place for people in three sets of records observed, but these had not always been completed in full and did not have clear action plans when people were at 'high risk'.

For example two people case tracked had 'high risk' Waterlow scores, but did not have detailed pressure area management care plans in place. Both people were being cared for on air mattresses and MDT daily records detailed that they were being turned regularly and for one person it had been recorded that cream had been applied to 'red areas', potentially an early sign of tissue damage. There was evidence staff were responding to people's clinical needs, but the care plans in place did not fully support this.

Hand over information summary sheets were given to the nursing team on IPU at handover with printed details about all people in patient on the unit. These were destroyed at the end of each shift. These were observed in use.

People did not routinely receive care and treatment that was appropriate, met their needs and/or reflected their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Various staff we spoke with could describe how services had adapted and changed in response to people's needs. For example, the hospice had seen a large increase in the numbers of children referred to its children's bereavement support services. They had therefore increased the resources dedicated to this service to better meet people's needs.

Another service provided was a weekly health and wellbeing group. This was initially planned to run for ten

weeks but people gave feedback that this was too long, and in response the group was re-modelled to run for a shorter period to reflect people's preferences.

Staff described the 'one stop shop' responsive approach used with people accessing a medical assessment/ diagnostics and treatments in the therapy day service. This helped to limit admissions to the local hospital or IPU at the hospice and enabled people to spend more time at home. Staff told us two people had received blood transfusions and six people had received assessments in the palliative care clinic during the week.

The community team, hospice at home team and specialist palliative care medical team offer home palliative/ End of Life (EoL) support to those choosing to receive care at home.

The medical staff said they made 200 home visits in 2014 and 500 home visits in 2015. Numbers of home visits have increased over the last few years and the lead clinician said this was most probably due to the success of the hospice at home service. The medical team run a weekly palliative care outpatient clinic on Tuesday mornings. They use emergency care plans to respond and support people to help divert them from unnecessary admissions or A&E attendances.

There was information in the reception area about how people could make a complaint if they wished. This was also included in information leaflets about the service. We looked at records of complaints and found that they were retained in a central register. This showed that each complaint was responded to promptly, and the outcome of any investigation was recorded. There was also information showing whether the complainant was happy with the outcome and details of any learning points or required changes to practice.

Is the service well-led?

Our findings

There was an open and positive culture at Rotherham Hospice which focused on people who used the service. People, relatives, staff and other care professionals spoke very positively about their experiences with the hospice. Comments included, "The organisation is well led and organised and I am confident if any concerns were raised they would be dealt with quickly," "The management of the hospice is very approachable and listens," "The Care is second to none" and "The service and level of care my relative and my family received from the Rotherham Hospice was exceptional."

The service had a registered manager as well as other senior staff who were responsible for the various aspects of service delivered by the provider. The hospice was overseen by a board of trustees who, as well as attending board and management meetings, attended the hospice regularly.

The hospice's management systems were supported by a formal structure of committees and governance groups. We checked the minutes of recent meetings to assess their effectiveness. The senior management team meeting looked at areas for improvement and development; monitored referrals and looked at plans to address increasing need for the hospice's services within the community. This meant that senior managers within the service had oversight of developments and the needs of people who used the service.

Medical and nursing staff said they attended the hospice Clinical Governance Committee and Trust Board meetings. They also linked in with the Patient Safety and Clinical Risk Management Group. These meetings had minutes distributed, so staff could get feedback if they were not able to attend.

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There was also a fortnightly safety and risk management group, again attended by senior personnel within the hospice. This group monitored accidents and incidents, looking to analyse trends and patterns in order to improve safety. The group also had oversight of complaints, safeguarding, risks and the Deprivation of Liberty Safeguards. This allowed senior personnel to contribute to and improve safety within the service.

Minutes of each committee and governance group meeting showed that action plans were developed from each meeting. These were revisited at the commencement of the subsequent meeting to ensure agreed actions had been carried out or remained on the agenda to ensure they were completed.

The provider produced an annual quality account. This was an assessment of how the service had met its targets across the preceding year, and what targets were to be set for the coming year. One target for the previous year had been improving accessibility. In response to this, we saw that the provider had formalised its 24 hour service, and had assessed that it had responded to 225 "out of hours" calls since its commencement. The quality account concluded that this was evidence that it was responding to people's changing needs.

The quality of service provided was measured by audits and evaluations, the results and findings of which were reported to the board of trustees and senior management. This meant senior management should be able to identify what areas to focus on for improvements or remodelling to better meet people's needs, as

well as recognise which areas were working well.

Issues, which included the two breaches of the regulations, had not been identified through an effective monitoring system. These systems need to be improved to ensure the systems are robust and identify issues emerging and prevent putting people at risk.

We spent some time speaking with the chief executive and registered manager. They told us of they would be putting action plans in place to address the issues of concern we had identified and looking again at the assurance systems so issues of concerns could be identified and addressed.

Staff told us that they found the management team within the hospice to be approachable and accessible. They told us they felt supported by their managers. Minutes and records of senior staff meetings showed that where possible staff requests to tailor their working patterns to personal and home commitments were honoured, allowing staff to improve their work/life balance.

Staff we spoke with were confident in their knowledge about how to raise concerns or give feedback to managers. There was a whistleblowing policy in place to support staff who had any concerns, and this was made available to staff during their induction.

Staff and volunteers we spoke with told us how proud they were to work at the hospice and how fulfilling their job was, comments included, "I feel proud when I tell people I work at Rotherham Hospice," "Everyone gets on and everyone is enthusiastic about palliative care" and "I feel honoured to work here."

The hospice policies were comprehensive, reflected every aspect of the delivery of care in the service and were updated continually. Staff were made aware of updates and knew where to locate the policies for guidance.

Rotherham Hospice has a key role in the local community and was actively involved in building further links. There were many organised events such as the 20th anniversary ball, charity football matches at local professional clubs, Proms in the Park and retail sales. Volunteers and staff contributed to the planning of events. There was a fundraising team who ensured the hospice maintained a high profile in the community and was regularly prominent in the local press.

The hospice publishes a regular magazine that is distributed within the borough called 'Rotherham Hospice Voice'. The magazine contains articles from people who use the service, their relatives and staff and forthcoming fundraising events.

The registered manager was aware of their responsibility to inform the CQC about notifiable incidents and circumstances in line with the Health and Social Care Act 2008.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Diagnostic and screening procedures	People did not routinely receive care and treatment that was appropriate, met their needs and/or reflected their preferences.
Transport services, triage and medical advice provided remotely	
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.
Transport services, triage and medical advice provided remotely	
Treatment of disease, disorder or injury	