Arthur Rank Hospice

Quality Report

Shelford Bottom
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	**Outstanding** ☆
Are services safe?	**Good** ●
Are services effective?	**Good** ●
Are services caring?	**Outstanding** ☆
Are services responsive?	**Outstanding** ☆
Are services well-led?	**Good** ●

Overall summary

The Arthur Rank hospice is operated by the Arthur Rank Hospice Charity. The hospice runs a number of services including 23 inpatient beds and a hospice at home night service from 10pm to 7am seven days a week, a specialist palliative community nursing team that conducts assessments and provides patients with advice in their own homes. The service also runs day hospice centres from the Arthur Rank Hospice site and a separate site in Wisbech and specialist palliative care outpatient clinics including a lymphoedema clinic and complex pain management clinic.

The hospice provides care and treatment for patients with a life-limiting condition who are aged 18 years or over.

We inspected this service using our comprehensive inspection methodology. We carried out the short-announced part of the inspection on 5 December 2018. An unannounced follow-up inspection took place on 18 December 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services:

Summary of findings

are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout our inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

We rated this service as **Outstanding** overall.

- Staff kept patients safe from harm and abuse. Risks were assessed, monitored and managed appropriately.
- Staff followed best practice in relation to infection prevention and control.
- Care and treatment records were accurate, stored securely and provided comprehensive details of care and treatment.
- Staff recognised incidents and knew how to report them. Managers investigated incidents and made improvements to the service.
- Staff had the appropriate skills, training, knowledge and experience to deliver effective care and treatment.
- Staff delivered care and treatment in line with evidence-based practice.
- Staff involved patients and carers in decisions about their care and treatment.
- Staff cared for patients with compassion, treating them with dignity and respect. Staff truly respected and valued patients as individuals and empowered them as partners in their care, practically and emotionally, by offering an exceptional service.
- The service was proactive in meeting the needs of people from their whole community. The services provided reflected the needs of the population served and ensured flexibility, choice and continuity of care.
- The service was proactive at engaging with groups that were hard to reach to ensure equitable access to its services.
- There were clear processes for staff to manage complaints and concerns.
- There was an open and transparent culture, with engaged and experienced leadership.

However, we also found the following issues that the service provider needs to improve:

- The maintenance and of equipment did not always keep people safe. We found out of date consumable equipment and one piece of electrical equipment that had not received a service within the hospice's agreed timescales.
- Not all outcome measures collected by the service were reported on during governance meetings meaning that outcome measures did not always shape and improve services.

Amanda Stanford

Deputy Chief Inspector of Hospitals (Central)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospices for adults	**Outstanding** ☆	Hospices for adults was the only activity provided at this location.

Summary of findings

Contents

Outstanding ☆

Arthur Rank Hospice

Services we looked at
Hospices for adults

Summary of this inspection

Background to Arthur Rank Hospice

Arthur Rank Hospice is operated by Arthur Rank Hospice Charity . The original Arthur Rank Hospice on Mill Road, Cambridge opened in 1982. The service opened a new purpose-built hospice in 2016. The hospice primarily serves the communities of the Cambridgeshire area.

The new hospice has 23 beds, 12 of which are specialist palliative care beds which are commissioned by the CCG. In December 2017 the service opened additional beds in collaboration with a local NHS Trust l (which is 1.7 miles away). The service operates 9 beds in partnership with the local hospital, these are for patients who have been assessed as having two weeks to live and who would be likely to die on a hospital ward.

The hospice also provides a specialist palliative care community nursing team advice line, from 9am to 5pm seven days a week. Out of hours, advice could be sought by telephone through the inpatient unit. A hospice at home service, day therapy service and outpatient clinics for lymphoedema patients was also available.

The service offers psychological support, physiotherapy, occupational therapy and bereavement support to patients and their relatives.

At the time of our inspection, a new registered manager had recently been appointed and was registered with the CQC in November 2018. A registered manager is a person who has registered with the CQC to manage the service. They have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is run.

Arthur Rank Hospice had not been inspected before. We inspected the service on 5 December 2018, our inspection was announced at short notice, to ensure that everyone we needed to speak with was available. We then carried out a follow-up unannounced inspection on 18 December 2018.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, a CQC medicines Inspector and a specialist advisor with expertise in end of life care. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Information about Arthur Rank Hospice

The hospice had one inpatient unit with 23 beds and is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury.
- Personal care

During our inspection, we visited the inpatient unit, the day therapy centre and attended a home visit with a member of the specialist palliative care community nursing team. We spoke with 22 staff including; registered nurses, health care assistants, reception staff, medical staff, chaplaincy staff, HR staff and senior managers. We spoke with four patients and four relatives. During our inspection, we reviewed seven sets of patient records.

There were no special reviews or investigations of the hospice ongoing by the CQC at any time during the 12 months before this inspection. This was the services first inspection since registration with CQC, which found that the service was meeting all standards of quality and safety it was inspected against.

Summary of this inspection

Track record on safety (October 2017 to October 2018). There were effective processes to report and record incidents. The service learnt from incidents and shared this learning effectively with staff. The service had:

- Zero Never events.
- Zero incidences of hospice acquired Meticillin-resistant Staphylococcus aureus (MRSA),Meticillin-sensitive staphylococcus aureus (MSSA), hospice acquired E-Coli. The service had one instance of hospice acquired Clostridium difficile (c.diff).
- Three serious incidents.
- Six complaints.
- 271 written compliments.

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal.
- Interpreting services.
- Maintenance of medical equipment.
- Piped Oxygen maintenance.
- Cleaning services on the inpatient unit.
- Pharmacy services.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **Good** because:

- Staff received mandatory training in safety systems, processes and practices.
- Staff kept patients safe from harm and abuse. Patient risks were assessed, monitored and managed appropriately.
- Staff followed best practice in relation to infection prevention and control.
- Care and treatment records were accurate, stored securely and provided comprehensive details of care and treatment.
- Staff followed best practice when prescribing, giving and recording medicines.
- Staff recognised incidents and knew how to report them. Managers investigated incidents and made improvements to the service.

However,

- We found consumable equipment that had passed its expiry date.

Are services effective?

Good

We rated effective as **Good** because:

- Staff delivered care and treatment in line with evidence-based practice.
- Information about the outcomes of patient care and treatment was routinely collected and monitored.
- Staff understood the importance of nutrition and hydration for effective care and treatment.
- Staff assessed and managed patient's pain well.
- Staff had the appropriate skills, training, knowledge and experience to deliver effective care and treatment.
- Consent to care and treatment was sought in line with legislation and guidance.
- There was effective multidisciplinary working across the service.

Are services caring?

Outstanding

We rated caring as **Outstanding** because:

- Staff truly respected and valued patients as individuals and empowered them as partners in their care, practically and emotionally.

Summary of this inspection

- Feedback from people who used the service, those who are close to them and stakeholders was continually positive about the way staff treated people. Patients said that staff went that extra mile and their care and support exceeded their expectations.
- Staff could provide multiple examples of where they had gone the extra mile to ensure person-focussed, exceptional care. Including displaying patients photographs to make them feel valued, funding individual adaptations to a patient's home to ensure they could be cared for in their chosen environment and offering moulds of patient's hands as mementos.
- Staff consideration of people's privacy and dignity was consistently embedded in everything that staff did.
- Staff prioritised the individual needs of patients by ensuring that they understood how they could help the patient and demonstrated innovative ways to meet their needs.
- The hospice provided emotional support to patients and their relatives through offering a range of psychological support options. One patient told us the emotional support they had received from the service had been "invaluable" and that they had previously been struggling with the process of dying but the psychologist had set their mind at rest.

Are services responsive?

Outstanding ☆

We rated responsive as **Outstanding** because:

- The service had a proactive approach to understanding the needs and preferences of different groups of people and delivered care in a way that met these needs.
- The service actively engaged with different groups that were seldom heard to ensure equitable access to its services.
- The design of the inpatient unit and hospice building had been created with the needs of patients and their relatives at the forefront of planning.
- People's individual needs and preferences were central to the delivery of tailored services. The service were flexible and provided informed choice and ensured continuity of care.
- The service had identified where people's needs and choices were not being met and used this information to inform how services were improved and developed.
- There were clear processes for staff to manage complaints and concerns and staff at all levels in the organisation were engaged with improving services as the result of complaints.

Are services well-led?

Good

We rated well-led as **Good** because:

Summary of this inspection

- Service leaders had the capacity and capability to deliver high-quality, sustainable care.
- The service had a clear vision and strategy that all staff understood and put into practice.
- Staff described the culture within the service as open and transparent. Staff could raise concerns and felt listened to. They said leaders were visible and approachable.
- The service had governance, risk management and quality measures to improve patient care, safety and outcomes.
- The service had effective systems in place to capture staff and patient feedback.
- There were systems in place to improve services by learning, continuous improvement and innovation.

However,

- Not all outcome measures collected by the service were reported on during governance meetings meaning that outcome measures did not always shape and improve services.
- The service did not have effective systems in place to monitor equipment maintenance and expiry on the inpatient unit.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospices for adults	Good	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding
Overall	Good	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding

Outstanding

Hospices for adults

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

Are hospices for adults services safe?

Good

We had not rated this service before. We rated safe as **good.**

Mandatory training

The service provided mandatory training in safety systems, processes and practices.

- Staff undertook a system of annual mandatory training to ensure they remained suitably skilled for the role they provided. Mandatory training topics included the Mental Capacity Act, safeguarding children and adults, moving and handling, conflict resolution, infection prevention and control, equality and diversity, fire safety, basic life support and health and safety. The training was a blend of e-learning and face-to-face sessions.
- The service set a mandatory training completion target of 95%. In November 2018, the overall compliance rate for mandatory training was 93%, which fell slightly below the service's target. The service had achieved a mandatory training rate of 95.1% in September 2018, but the service had employed new staff which had led to the November decrease.
- Each individual mandatory training topic had a compliance rate of over 91% except infection prevention and control training for clinical staff which was at 53%. The service had identified this as an area for improvement on their clinical dashboard and discussed actions to improve rates as part of their business and care board meetings.
- In September 2018 the service had achieved a 99% rate of all clinical staff who had completed their basic life support training.
- The inpatient unit (IPU) had a mandatory training champion who monitored the IPU team's compliance rates and assisted staff to book on to training.
- There was a structured induction programme for staff to ensure they had the skills needed for their roles. The service's induction programme included ensuring new staff could access the computer systems, meeting with staff in different departments and teams and dedicated time to complete mandatory training. The induction programme was supported by individualised induction packs for staff. The packs included an induction timeline, e-learning requirements and activities such as attending ward-rounds and meeting patients, which were signed off by a senior member of staff when completed.

Safeguarding

The service had effective processes in place to keep people safe and protected from abuse.

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff received training on how to recognise and report abuse and staff we spoke with knew how to raise safeguarding concerns.
- Safeguarding systems and processes ensured patient safety. The service had a safeguarding vulnerable

adults policy which was dated April 2018 and contained details on recognising and reporting abuse. This was accessible to staff on the service's intranet. Safeguarding flowcharts were visible in the offices of the inpatient unit and the day therapy area which had the details of who to contact in the event of safeguarding concerns.

- The service had a safeguarding training target of 95%. The service's training data showed that 96% of staff had been trained to Safeguarding Adults Level 1 and 95% had been trained to Safeguarding Adults Level 2.
- Though the hospice was for adults only it had taken a proactive approach in recognising potential children's safeguarding concerns and had three members of staff with increased responsibility for safeguarding trained to children's safeguarding Level 3. Volunteers within the service undertook face-to-face safeguarding Adults Level 1 training as part of their induction.
- The service's social worker was the lead for safeguarding, who provided advice and support for staff with making referrals.
- Staff we spoke with were knowledgeable about different types of abuse and told us they would escalate concerns to the senior member of staff on duty or the safeguarding lead. This was in line with the service's policy.
- No safeguarding incidents had been reported by the inpatient unit from September 2017 to September 2018.
- Safety was promoted through the recruitment and induction of volunteers and staff. The service used an external company to determine which volunteer roles required a Disclosure and Barring Service (DBS) certificate. DBS checks involve a government department carrying out a criminal record check that results in a certificate being issued to an individual. The service had conducted a recent audit of their volunteers to determine which volunteers did not have a DBS in order to remedy this. Of these roles that required a DBS check, 95% of volunteers had a DBS in place. We saw evidence that the remaining 5% of volunteers were in the process of obtaining a DBS. However, they were currently working for the service without a DBS certificate.
- The service had systems in place to ensure that all clinical staff received a DBS certificate prior to starting their roles. We reviewed a new starter folder and saw that a DBS certificate was in place and that this corresponded with the service's electronic monitoring of DBS certificates.
- The service had a policy in place for chaperones and we saw that patient records included tick-box sections to indicate that a chaperone had been offered to patients. The service had posters in areas where outpatient clinics were held, informing patients they could request a chaperone.

Cleanliness, infection control and hygiene

Staff followed best practice in regard to infection prevention and control.

- There were systems in place to protect patients from, and prevent, healthcare-associated infections. The service had recently created an infection prevention and control (IPC) handbook for staff, which contained all the service's policies and guidance on IPC in one booklet. This booklet was readily available for staff to access.
- There were effective arrangements in place to prevent the spread of infection when caring for patients who had died. Systems ensured deceased patients left the hospice in a timely and dignified way and any risks of cross-infection were appropriately managed.
- The service undertook hand hygiene audits for the inpatient unit, the day therapy centre and the outpatient lymphedema clinics. Between November 2017 and October 2018, the audit demonstrated 100% compliance. The service did not conduct hand hygiene audits for its community services; however, the community lead nurse had previously attended night shifts with staff to check on IPC and was satisfied with the levels of compliance from community nursing staff.
- The service had an IPC lead who chaired the quarterly IPC and health and safety meetings. The meetings discussed IPC incidents and infection rates.
- Between August 2017 and September 2018, the service had no instances of the following healthcare acquired infections Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive

Staphylococcus aureus (MSSA) or Escherichia coli (E-coli). However, the service had one instance of a patient developing Clostridium Difficile (C. Diff). This patient had recently been taking antibiotics. C. Diff is a bacterium that can infect the bowel and cause diarrhoea. The infection most commonly affects people who have recently been treated with antibiotics and can spread easily to others. The service followed their IPC policy and liaised with the CCG and local microbiologist to prevent the spread of infection and identify any learning.

- The hospice was visibly clean and clutter free. Equipment had 'I am clean stickers' in use to indicate that equipment was clean and ready for patient use.
- Staff adhered to the service's arms bare below the elbows policy as well as using appropriate protective equipment (PPE) such as gloves, and aprons to deliver personal care. We observed staff washing their hands before and after patient contact.
- The service had a service level agreement with an external company to clean the inpatient unit. The service monitored the effectiveness of the cleaning through weekly audits that looked at the cleanliness of multiple areas including bed pans, commodes, medical equipment, floors, beds and toilets. Staff told us that they would challenge the external contractor if the results of the audit fell below an agreed standard. The results of the audit were displayed on the inpatient unit and showed that the standards were met for October 2018.

Environment and equipment

There was a system in place for managing electronic equipment within the service however this was not replicated to ensure that consumable equipment was checked and replaced.

- The service held an electronic register of electronic and medical devices that required servicing. The register listed the servicing expiry date. Staff told us that this was not monitored regularly and that they did not know who held responsibility for ensuring that the equipment on the register was serviced. We raised this with the senior leadership team and when we returned to inspect the service unannounced on the 18 December the service had implemented a new system to check equipment and ensure oversight by the clinical services support manager.
- We checked ten pieces of consumable equipment and found that two pieces had gone past their expiry date. One was a pair of sterile gloves and the other a large box of tracheostomy tubes. Staff told us the service did not have any processes in place to check that consumable equipment was in date. We raised this as a concern to the senior leadership team who removed the out of date equipment from circulation and informed us that a process would be devised to ensure expiry dates on consumable equipment was checked.
- The service had a defibrillator, which was located in the service's reception. A defibrillator is a device that gives a high energy electric shock to the heart through the chest wall to someone who is in cardiac arrest. The defibrillator and pads were checked weekly and that staff we spoke with were aware of its location.
- A syringe driver is a small infusion pump, used to gradually administer small amounts of fluid medication under the patient's skin. Syringe drivers were provided by the service but serviced annually and maintained by an external company. All syringe drivers were serviced and tested in accordance with manufacturer guidelines. We saw that staff had been trained to use syringe drivers and their competency to do so assessed.
- The service had a maintenance team who were onsite during working hours and provided an on-call service out of hours. Staff told us the maintenance team were responsive to calls and fixed equipment promptly.
- Staff told us that specialist equipment such as syringe drivers and hoists were readily available. The service had a room equipped with bariatric equipment to enable bariatric patients to be safely cared for on the inpatient unit. Bariatric equipment is equipment that is in place for obese patients.
- Staff had access to specialist medical equipment such as profiling beds, pressure relieving mattresses and pressure relieving boots.

- Call bells were accessible for patients in their rooms to alert staff if a patient required assistance. The call bells worked remotely, without wires to enable patients to access them wherever they were positioned.
- Entry to the inpatient unit was by fob and staff used, an intercom system enabled relatives and patients to access the unit.
- The service had appropriate arrangements in place for the management of clinical waste and sharps. Arrangements for storing, classifying and labelling clinical waste kept patients and staff safe.

Assessing and responding to patient risk

Staff assessed, monitored and managed patient risk.

- Comprehensive risk assessments were carried out for patients and risk management plans were developed in line with national guidance. We found evidence that risks such as falls and pressure ulcers were managed positively by the service.
- Staff completed an initial risk assessment within 12 hours of a patient being admitted and repeated this when a patient's circumstances changed. The service assessed the risks of pressure ulcers, manual handling, falls, venous thromboembolism (VTE), use of bedrails, nutrition, continence and mouthcare for all patients on admission.
- Patients conditions were reviewed regularly within the service. The specialist palliative care beds and patients on an end of life care plan received a review from a doctor daily. We saw evidence of this in the seven patient notes that we reviewed. The patients admitted to the nurse-led beds were reviewed daily by the nursing team and their care was were escalated as necessary to the medical team. All patients received a review by a consultant on Mondays and Thursdays. There were processes in place to escalate concerns with patient's deterioration and medical emergencies to senior nursing and medical staff. Senior nursing staff and medical staff were onsite seven days a week and could be accessed by telephone out of hours.
- The service positively managed risks that people might experience at the end of their life, including risk of pressure ulcer and falls. Staff used nationally recognised tools to assess each person's risk of developing pressure ulcers. This was re-assessed weekly. Each patient's skin integrity was checked and recorded three times a day and formed part of the services two-hourly comfort rounding. We saw the patients had the correct pressure relieving equipment in place according to their level of risk.
- Comfort rounding was used to ensure patients were comfortable.Records indicated that staff assessed patients skin integrity, risk of falling, positioning for comfort, toilet requirements, mouthcare, food and drink offered, symptoms such as pain and nausea and that the environment was clutter free with the call bell to hand for the patient.
- The hospice had recently undertaken a project to reduce the number of falls that patients were experiencing. The service mapped when they experienced the highest number of falls and found it was during twilight hours in the morning. As a result, the hospice introduced a twilight shift, which enabled them to plan for an extra member of staff if a patient was at high risk of falling.
- Other outcomes of the project included redesigning the falls assessment. The falls assessment was adapted to include an assessment of medications that might increase each patient's risk of falling. The new assessment looked at a patient's mobility, history of falls, toileting concerns, cognition and communication skills. The falls bundle also included a falls flowchart which detailed what staff should do in the event of a patient falling . We saw the falls assessments completed in full for all seven of the patient records we reviewed. In addition to this the service held a post-fall multi-disciplinary meeting when a patient did fall to look at possible causes and what could be done to prevent a future occurrence. The meetings were attended by physiotherapists, doctors and nurses.
- The service provided slippers to patients that they had assessed to be at a falls risk. They did this following research that supportive footwear could reduce falls risk in patients. Staff told us that since the new falls measures had been in place they had seen a reduction in the number of falls patients experienced.
- The falls risk assessment booklet stated that patients were to be reassessed for their falls risk a week after

admission. We saw that the re-assessment was not completed for two out of the seven patient notes that we reviewed. We raised this with the ward matron who informed us that all records would be reviewed.

- Patients who were at the end of their life were placed on the services personalised care for the last days of life plan. The plan included a medicines review, ensuring a Do Not Attempt Cardiopulmonary Resuscitation order (DNACPR) was in place, making note of any advance care plans and relatives wishes, nutrition and hydration assessments and care plans for pain management, agitation, respiratory symptoms, mouthcare, spiritual and psychological care. All seven sets of patient records we reviewed had completed DNACPR forms. We saw that it was a requirement of the nurse led beds that a patient had a DNACPR in place prior to transfer to the hospice.

Nurse staffing

The service had enough staff to meet the needs of patients.

- The service had enough nursing and health care staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The service had determined a minimum safe staffing level using a nationally recognised staffing tool. The inpatient matron had discretion to judge additional staffing levels based on the acuity of patients.
- To ensure safe staffing levels at all times, the service used bank staff and staff worked flexibly across different service areas. The service ensured a senior nurse was always on duty on the inpatient unit and that staff had access to an on-call manager in and out of hours to escalate any staffing concerns that arose. The service did not use agency staff.
- Patients numbers were managed to ensure sufficient staff were available; the service had the ability to decline patients if they felt that admitting them would be unsafe due to staffing levels. On our inspection we saw the service had declined patients in September 2018 in order to ensure safe staffing levels were maintained.
- The service had two whole time equivalent (WTE) registered nursing vacancies and 2.6 WTE Health Care Assistant vacancies on the inpatient unit. In the community the service had 0.8 WTE clinical nurse specialist vacancies.
- The service had a sickness rate of 5.07% between July and September 2018. The service did not have a target rate for sickness but monitored its sickness rates against triggers in their sickness policy.
- We saw that planned levels of staffing matched the actual staffing levels on the day of our inspections and that there was a strong skill mix among the nursing team.

Medical staffing

The service had enough medical staff to meet the needs of patients.

- The service had access to appropriate medical input. There was one full time consultant and two part-time consultant's working for the service with cross-site working at local hospitals. The hospice had onsite consultant cover from 9am to 5pm on weekdays. The consultants provided support to the inpatient unit and the community teams. There was a consultant on call from 5pm to 9am and throughout weekends to ensure twenty-four-hour, seven day a week cover. The service's consultant out of hours rota was shared with five consultants at the local hospital. Doctors within the service told us that this was effective and gave the service access to consultants with a breadth of experience and allowed joined up working between the services.
- The consultants were supported by two speciality palliative care doctors, one full-time core medical trainee and a part-time GP trainee who worked on the inpatient unit. The service had a first-on-call out of hour rota for these doctors that also included a pool of locum GP's with an interest in palliative care. The rota provided out of hours cover for 365 days of the year.
- The service conducted a consultant ward round every Monday with a consultant review on a Thursday. Speciality doctors performed a ward round daily to

review patients. New patients were discussed with, or reviewed by a senior doctor on the day of admission or by one of the consultants within one to two working days.

Records

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

- People's individual care records were written and managed in a way that kept people safe. Staff kept detailed records of patients' care and treatment.
- Patient records were stored securely in the nurse's office. The office was accessed by a coded key pad, which could only be accessed by authorised staff.
- We reviewed seven patient care records. The records contained comprehensive and person-centred care plans which clearly identified patients' emotional, social and spiritual needs alongside their physical health needs. Staff completed care plans appropriately and we saw they recorded when care was carried out in line with the care plan. Staff reviewed care plans weekly or when a patient's circumstances changed.
- Staff could access patient specific information from the care plan which included information on communication, psychological and mental health and end of life care. All care records contained a 'getting to know me' document that detailed the patient's needs and preferences and took account of any additional needs such as dementia and behavioural needs. This was completed in six out of the seven care records we reviewed.
- The information needed to deliver safe care and treatment was available to staff in a timely and accessible way. The day hospice and community service used an online system for recording of patient's records and the inpatient unit used paper-based records. However, there was a plan in place for the inpatient unit to have an electronic records system by December 2019.
- Information needed for each patient's ongoing care was shared appropriately in a timely way. The service sought and obtained patient consent to share information with other services such as GP's. The service sent discharge letter to the patients GP by fax. The inpatient unit could access to the community and the day hospice's electronic system as well as access to the local hospitals record system for patients that had been transferred from the hospital or community.
- The service undertook a records audit in November 2018 to assess the quality of records. The audit identified concerns with patient identifier stickers as well as accuracy and legibility of documentation for the nurse led beds. The service formulated a plan to address the concerns including circulating expected standards to all staff, presenting audit findings during training and ensuring that induction packs clearly explained the standards expected in record keeping. On our inspection we did not find the issues identified in the audit with records.

Medicines

Staff followed best practice when prescribing, giving and recording medicines.

- A medicines inspector looked at how medicines were managed at the service. We checked patient records and prescription chart for seven patients as well as looking at the medicines management group agenda and minutes, medicines standard operating procedures and policies and controlled drug records and drugs audit records. We also spoke with six members of staff in relation to the management of medicines.
- The service had a controlled drugs accountable officer and a service lead for the safe and secure handling of medicines.
- The service had a service level agreement with the local hospital for pharmacy support. Two pharmacists worked part time on the inpatient unit and were available for support as part of the medicines management team.
- Medicines were stored safely and securely, in locked medicine cupboards within a treatment room. There was a system in place to check that all medicines were within date and suitable for use. Night staff carried out nightly stock checks to ensure medicines had not expired and to place orders to replenish stock levels.

- There were medicines available for use in an emergency and these were checked regularly. Medicines requiring cold storage were kept in a refrigerator within recommended temperature ranges and this was monitored regularly.
- Controlled Drugs (CDs), medicines that require additional controls because of their potential for abuse, were managed effectively. The controlled drugs were stored appropriately and the service had recently installed a key safe with fingerprint access by authorised staff. CDs were destroyed on the premises by a pharmacy technician and witnessed by a registered nurse. We saw that clear records of this were kept. Pharmacists carried out three monthly audits on controlled drugs.
- Medicines were prescribed, prepared and administered by competent staff. Nurse's CD competencies were checked annually and doctors were provided with training on prescribing and the services policies by a trained pharmacist on induction. On admission doctors completed an inpatient medicines reconciliation report for patients which was then checked by a pharmacist for accuracy and signed.
- Patients' prescriptions and administration records were accurate, complete, legible and stored securely. Allergy statuses of patients were recorded on prescription charts.
- For patients receiving medicines through a syringe pump, checks were carried out 4 hourly by nurses and this was clearly documented.
- Staff had access to current references to ensure the correct and safe administration of medicines.
- Patients were given clear information on the medicines they were receiving. We spoke with one patient who felt they were given clear and accurate information on medicines they were given and their expected effect. The patient felt able to ask questions and involved in decisions about their medicines.
- At the time of our inspection, no patients were self-administering their medicines but systems were in place to support this should they wish to do so. Medicines administration records (MARs) were appropriately completed and there were no omissions. A weekly audit was also undertaken to ensure people were administered their medicines as prescribed.
- Medicine related incidents were recorded and monitored, lessons were learnt and action plans were in place to ensure recurrence of errors was minimised.
- There was a system in place to ensure that medicines alerts or recalls were actioned appropriately.
- Pharmacists reviewed the prescribed medicines for patients regularly and were involved in the training of staff on medicines optimisation and attended multidisciplinary team meetings.
- The pharmacy team were not directly involved in the hospice at home teams or day therapy service but there were representatives of both services at the medicines management meetings where any issues relating to medicines were discussed.
- The service stored medical gases in line with manufacturers best practice guidelines. Used oxygen cylinders were stored in an external locked cage and cylinders that were in use were stored in a ventilated room that had signage stating that the room contained oxygen. The service had piped oxygen in all the rooms, which was maintained by an external company. However, this was checked weekly by the service's maintenance team.

Incidents

There were effective processes to report and record incidents. The service learnt from incidents and shared this learning effectively with staff.

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learnt with the whole team and wider service. When things went wrong, staff apologised and gave patients honest information and feedback.
- The service reported no never events from September 2017 to September 2018. A 'never event' is a serious patient safety incident that should not happen if healthcare providers follow national guidance on how

to prevent them. Each never event reported type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

- From September 2017 to September 2018, the service had three serious incidents. The serious incidents involved a medication error, a patient fall and patient who was not appropriately prescribed fluids and developed hypernatremia, which is a common electrolyte problem that is a defined rise in serum sodium concentration levels. We reviewed the three serious incident root cause analysis investigations and saw that the investigations were detailed and that root causes and learning were identified alongside a plan for sharing the learning with staff.
- Staff reported incidents using the online incident reporting system. Through this system service managers, the director of clinical services and the chief executive officer were notified of incidents to maintain oversight. Incident investigations on the inpatient unit were overseen by the IPU Matron who was responsible for completing the investigation. The IPU Matron had been trained in route cause analysis investigations. Staff told us they were encouraged to report incidents including near misses.
- Staff could provide examples of learning from incidents. Nursing staff told us about an incident which occurred earlier in the year relating to the administration of a medicine at the wrong strength. The incident was reported, a full investigation and root -cause analysis was undertaken, learning from the incident was shared with other staff and a consultant led training session on ketamine dosing was also delivered to the nursing staff. As a result of the incident the hospice decided to keep only one strength of the medicine to reduce the risk of errors occurring in the future.
- Staff told us that learning from incidents was shared in a number of ways including at staff handovers and staff training. Staff were circulated serious incidents reports which had to be read and signed by all staff. Medicine incidents and related outcomes were discussed at the monthly Medicines Management Group meetings and clinical care board meetings.
- Staff had a clear understanding of the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The service had a duty of candour policy dated October 2017 which detailed the requirements of staff under the duty of candour. The service had invoked the duty of candour in the three serious incident investigations we reviewed.

Safety Thermometer

The service contributed to the NHS safety thermometer and had consistent results of harm free care.

- The service submitted information to the NHS safety thermometer. From November 2017 to November 2018 the service had no instances of pressure ulcers, catheter related urinary tract infections (UTI), new Venous thromboembolism **(**VTE) or new patient harms.
- The service discussed the safety thermometer in the board meetings as part of the chief executive report. We viewed the September 2018 board meeting minutes and saw that the safety thermometer was a standing agenda item.

Are hospices for adults services effective?

(for example, treatment is effective)

Good

We had not rated this service before. We rated effective it as **good.**

Evidence-based care and treatment

Staff delivered care and treatment in line with evidence-based practice.

- People's physical, mental health and social needs were holistically assessed by the service and care and treatment was delivered in line with legislation, standards and evidence-based guidance.

- Patients had a clear personalised care plan that reflected their needs and was up to date. Staff delivered care to patients in the last days of life that met the 'five priorities of care of the dying person'. Individual care plans took account of symptom control, psychological, social and spiritual support and we saw evidence of discussion with patients and relatives recorded in care plans. This gave us assurance that care plans were agreed and developed with the consent of the patient.
- The service monitored the review of National Institute of Clinical Excellence (NICE) guidance and Medicines and Healthcare products Regulatory Agency (MHRA) alerts as part of the services dashboards which were presented at the monthly board meetings. We viewed the dashboard and saw the guidance was assigned to an owner within the clinical team to review. There was a system in place to ensure that medicine alerts were actioned appropriately by the pharmacy team.
- Anticipatory medicines for distress, agitation, seizures and pain were prescribed and given in line with NICE guidelines for care of the dying adult in the last days of life and palliative care for adults.
- Patient's attending the hospice in both the day therapy service and inpatient unit had the opportunity to develop an advance care plan. We saw in patient records that patients had the opportunity to create a specific guide to decision making in an emergency.
- The services policies and procedures and national guidance were reviewed and ratified by the clinical care board which was held bi-monthly. However, the service had 13 policies out of 260 that were out of date. This included the services serious incident policy, resuscitation policy and Mental Capacity Act and Deprivation of Liberty Safeguards policy. We saw that the Mental Capacity Act and Deprivation of Liberty Safeguards policy was over a year out of date. The service provided assurances that the policies had been reviewed and were in the process of being ratified.

Nutrition and hydration

Staff understood the importance of nutrition and hydration for effective care and treatment.

- Patients received a nutrition and hydration assessment on admission. Staff used a nutrition screening tool to assess the food and hydration needs of patients. The nutritional assessments were completed in full in all seven of the patient records we reviewed.
- Patient's nutrition and hydration was assessed and monitored as part of patients personalised care for the last days of life plan. This also included a mouthcare and oral hygiene plan. Discussions with patient's relatives about nutrition at the end of life were clearly documented in the plan.
- The service could refer patients to dieticians and speech and language therapists and staff were aware of how to access these services.
- Patients were offered a choice of meals from a menu each day and provided snacks and drinks throughout the day.

Pain relief

Staff assessed and managed patient pain well.

- The hospice managed the pain of people who were approaching the end of their life effectively. Staff assessed and monitored patients pain in two-hourly comfort rounds during the day and hourly during the night.
- Patient's pain management was discussed in both the community and inpatient unit weekly multidisciplinary team meeting. We saw evidence in patients records of ongoing pain assessments undertaken.
- We reviewed care records and saw patients had appropriate pain assessments and pain care plans. Staff recorded when as required medicines were prescribed and given for pain relief. Anticipatory medicines were prescribed appropriately in people identified as approaching the end of life.
- Staff used an appropriate tool to help assess the level of pain in patients who were unable to communicate verbally.

Patient outcomes

Information about the outcomes of patient care and treatment was routinely collected and monitored.

- The service monitored and benchmarked the quality of the services and the outcomes for patients receiving care and treatment. When benchmarked against similar services the hospice performed well. However, the service did not report on all outcomes collected to the board of trustees or senior leaders within the service and therefore quality and outcome information was not used to inform improvements to the service.
- The service used the Integrated Palliative Care Outcome Score (IPOS). This is family of tools that measure a patient's physical symptoms, psychological, emotional and spiritual, and information and support needs. Each patient was given an IPOS score when they were discussed at the community and inpatient unit (IPU) multidisciplinary team meeting.
- The service used the Karnofsky Performance Scale to classify patients as to their functional impairment. The score is used to compare effectiveness of different therapies and to assess the prognosis in individual patients. Each patient was given an Karnofsky score when they were discussed at the community and IPU multidisciplinary meeting.
- The service had implemented the Outcome Assessment and Complexity Collaborative (OACC) initiative which aimed to implement outcome measures in routine palliative care. We saw the outcome measures of the Karnofsy performance status and integrated palliative care outcome scale (IPOS) being used to assess patients in the services multidisciplinary team meeting. However, scores were not collated by the service or reported on in any other forum and therefore the service was not benchmarking these outcomes.
- The service submitted data on falls, pressure ulcers and medicine incidents to Hospice UK inpatient safety benchmarking reports. This allowed the provider to benchmark and compare their performance with other services nationally. The service had a lower than average falls rate, a lower rate of medicines incidents and a lower number of health care acquired pressure ulcers when benchmarked against other similar services. However, this data was not shared throughout the service or reported on in the clinical care board meetings and therefore did not inform improvements to the service.
- The service had to report on a number of outcome measures to the clinical commissioning Group (CCG) using a quality early warning trigger tool. The tool looked at complaint numbers, mandatory training compliance, staffing levels, and serious incidents. The service additionally reported the percentage of patients receiving a night sitting request within 12 hours of request, patients who are on the end of life care register, patients who had a do not attempt cardio pulmonary resuscitation (DNACPR) order in place at the time of their death, patients who had anticipatory medicines available and the percentage of patients who died in a hospice setting. The tool also formed part of the service's monthly dashboard which was discussed at the services care board meetings.
- Patients and relatives completed the 'Clinical Outcomes in Routine Evaluation (CORE)' survey to monitor the effectiveness of the psychological support offered by the service's patient and family support team. The services results for 2017 and 2018 indicated improved wellbeing and functioning between the sessions offered by the service and end of treatment.
- The service conducted a regular programme of audits. The programme included weekly medication omission audits, we saw that the service had an average score of 99.78 for the month of September 2018. The drug omissions audit formed part of the service's monthly dashboard.
- The service also completed a monthly essential steps audit which was a national tool that looked at infection rates for catheters, and intravenous lines as well as hand hygiene. The service scored 100% in these audits in September, October and November 2018.
- The service conducted other medicines audits including an audit on phenobarbital to review whether it was being used appropriately in palliative care. The findings from the audit demonstrated that prescribing in the unit was low and where it did occur dosing was appropriate.

- The service leads told us that the service could do more to audit and report on the effectiveness of services and had plans in place to improve the data collected by the service and the outcomes measured.

Competent staff

Staff had the appropriate skills, knowledge and experience to deliver effective care and treatment.

- Patients had their needs assessed by staff with the right skills and knowledge. The service ensured that staff competencies were assessed regularly and had implemented a dedicated clinical teacher to train staff. Competency assessments for registered nurses included medicines, intravenous lines, blood transfusions, naso- gastric tubes, syringe drivers and rocket drains. Rocketdrains are indwelling catheters designed to drain recurrent malignant effusion from the chest. Staff had a mentor responsible for signing off competencies.
- Staff mentors oversaw appraisals, mentoring, clinical and group supervision.
- Staff told us that they completed annual appraisals with their mentors and that they found these meaningful. The services appraisal rate for all staff was 91%, this fell slightly below the service's target of 95%.
- The service had an established induction process in place for all grades of staff. Induction on the inpatient unit was a three-week process where staff would spend the first two weeks completing classroom based activities such as mandatory training and reviewing policies and procedures. The induction process included an induction booklet with competencies to be signed off. Staff also shadowed another member of staff on the inpatient unit for a week. Bank staff received the same induction that permanent staff received.
- Staff were encouraged and given opportunities to develop. The service had an education team who were responsible for delivering a programme of education around palliative and end of life care. The education programme was open to all staff and to external healthcare professionals. The programme focussed on providing training on holistic palliative care and included sessions on end of life care across differing faiths, body image and sexuality, advanced communication skills in palliative care, and assessing the needs of the "whole person".
- The service employed a part time librarian who scanned medical and nursing journals for relevant articles and made staff aware of them. Once a month the service had a journal club where a new journal was discussed at length. Staff told us the journal club was well attended and they found the articles interesting and relevant to their roles.
- Volunteers were provided with appropriate training, supervision and support. The service had volunteer coordinators who supported volunteers by providing them with training and by offering telephone support. Volunteers had a full induction programme which included face-to-face safeguarding training.
- All staff and volunteers underwent equality and diversity training on induction which was repeated every three years.
- The human resources team monitored professional registration and revalidation for staff and sent reminders to staff when their registration and revalidation to professional bodies was due for renewal.

Multidisciplinary working

There was effective multidisciplinary working across the service.

- Multidisciplinary team working helped the effective planning and delivery of care and enabled the service to provide holistic support to patients.
- The day therapy service held a multidisciplinary team meeting every morning to discuss patient's treatment goals and to discuss their progress against their care plans. This meeting was attended by clinical nurse specialists, healthcare assistants, physiotherapists, occupational therapists, activities coordinator and complementary therapist and the chaplain. Care was then delivered to patients by the multidisciplinary team with patients able to access physiotherapy, occupational therapy, spiritual support, nursing support and complementary therapy in the day therapy setting.

- The hospice's multi-disciplinary team represented all aspects of holistic care. The service ensured a patient's physical needs were met through medicine and physiotherapy support. Patient's psychological needs were supported through the services psychologists who offered support to both patients and their relatives. Patients social needs were met by the services social worker and spiritual needs were met by the services multi-faith chaplaincy team.
- The chaplaincy team also supported the mental health needs of staff through offering drop in sessions and debriefs following significant events.
- The service worked effectively with professionals from other local services. The service was commissioned to provide nine end of life care beds for the local hospital and had a registered nurse based at the local hospital to assess patients who might be suitable to be admitted to the hospice. This provided a clear process for transfer of care from the hospital to the hospice. Staff reported the service had strong links with the local hospital and that services worked effectively together to ensure patients were provided with care to meet their needs.
- Staff within the service told us they worked effectively with professionals from other services and could refer to mental health services if required; and provided examples of when they had done so.
- The service participated in relevant external meetings including working together with the Gold Standards Framework (GSF) to deliver the GSF programme to services in East Anglia. The Gold Standards Framework provides training to all those providing end of life care to ensure better lives for people and recognised standards of care. Staff supported colleagues working in end of life care in other services in the community through delivering training programmes and workshops to care homes within the region to enable them to apply for GSF accreditation.

Health promotion

The service supported people to manage their health needs.

- The service focussed on enhancing quality of life for all patients using the service. The day therapy service identified patients in need of extra support and provided emotional support in addition to physiotherapy and care planning.
- The service ran healthy lifestyle workshops for patients and their families which included topics such as healthy eating, stress reduction and physical activity.
- The day therapy service had a gym with specialised equipment to allow patients to alleviate common palliative symptoms such as breathlessness and to support patients to maintain their own health and wellbeing.
- The day therapy service had developed a wellbeing group for patients who had finished their set day therapy group with the service but wished to continue to access the service's support and facilities.
- The service engaged actively with the community to support people who were approaching the end of their life and those who were important to them by running sessions in the service's garden studio, "Arthur's Shed". The sessions were open to patients, their relatives and the wider community and included activities such as singing, crafts, flower arranging and reminiscence groups.

Consent and Mental Capacity Act

Consent to care and treatment was sought in line with legislation and guidance.

- The service had a mental capacity and deprivation of liberty safeguards policy that was dated 4 March 2015. The policy was due to be reviewed in September 2017, as of our inspection the policy review had not been completed. However, the service confirmed that a new policy was in the process of being ratified.
- The service looked at each patient's mental capacity as part of the personalised care for the last days of life plan. We saw evidence that capacity was assessed prior to decisions about end of life care being made.
- The Mental Capacity Act 2005 allows restraint and restriction to be used if they are in a person's best interest. Extra safeguards, Deprivation of Liberty Safeguards (DoLS), are needed if the restriction and restraint used will deprive a person of their liberty. The

service used a deprivation of liberty monitoring form which provided a flowchart detailing what steps to take to place a patient under a DoLS. Staff we spoke with could describe the process of assessing capacity and the requirements for obtaining consent if the patient was assessed as lacking capacity.

- During our inspection three patients were subject to a DoLS, we saw evidence that staff had submitted the application and were waiting for a decision from the local authority and that a full mental capacity assessment had taken place and been recorded. All three mental capacity act assessments had been carried out appropriately.
- Do not attempt cardiopulmonary resuscitation (DNACPR) decisions were recorded on appropriate forms and completed accurately in all the patient records we reviewed.
- Where a patient had been assessed as not having the capacity to consent to treatment, staff acted in their best interests and this was discussed and agreed at the multidisciplinary team meeting.

Are hospices for adults services caring?

Outstanding ☆

We had not rated this service before. We rated caring as **outstanding.**

Compassionate care

We observed staff treating patients with compassion, dignity and respect throughout our inspection. Staff expressed a desire to provide patients with the best possible care at the end of their lives.

- Staff and patient's relatives provided us with many examples of where staff had provided compassionate and individualised care to patients and their relatives. One relative we spoke with told us how kind the staff were. They told us that during the hospice's annual carol service staff asked if the patient wanted to go outside and hear the carols and see the lighting of the Christmas tree. Patients also told us that staff ensured the patient had lots of layers on to keep warm and that staff had got the patient their favourite beverage to enjoy whilst watching the carol service.
- One patient told us that they felt that the staff were extremely caring and valued their contributions to the service by displaying in the day therapy centre photographs the patient had taken of the garden.
- Staff told us that the service conducted around four weddings a year for patients. Staff within the service did all they could to ensure these were special occasions. Staff had arranged to borrow chairs and seat covers from a local hotel and the service's hairdressers would come to the inpatient unit to style patient's hair for their weddings. The service had experienced difficulty in getting bouquets for weddings previously so had provided a floristry course for two members of their fundraising team so they could create unique bouquets for patients and their relatives.
- Staff told us they had supported a patient to attend their son's wedding by liaising with local ambulance crews and sending the patient with a speciality doctor so they could give the patient medication as required.
- Nursing staff were passionate about creating positive memories for patients and their families when staying at the inpatient unit. Staff showed us plaster moulds that they had created of patient's hands entwined with their relatives. They offered the opportunity to create and keep these moulds for all patients and their relatives.
- Staff within the service took the time to understand patients as individuals and plan care that was personalised to them. Staff gave the example of a patient that wished to be cared for at home but their home did not have suitable living arrangements. The service provided individual adaptations to the patient's home using money from benevolent funds so that the patient could be cared for in their chosen environment.
- Staff told us about an occasion where the staff had arranged air travel arrangements for a patient's relative in order to ensure that the patient could be cared for in their chosen environment.

- The hospice collected patient feedback on their services, the results of which were wholly positive. The service participated in the friends and family survey which asked whether the patient or their relative would recommend the service, the services results as of November 2018 were 100% positive responses to the question. The service had received 271 written compliments from1 September 2017 to 31 August 2018.
- Staff consideration of people's privacy and dignity was consistently embedded in everything that staff did. Staff ensured they protected patient's dignity when providing personal care by closing doors and curtains to bedrooms. The dignity of deceased patients was maintained through the services processes for performing last offices and transferring the deceased person to the services cold room to await collection by a funeral home. Last offices is the process to prepare the deceased for a funeral home and often involves washing the patient.
- The service's ensured that it returned the deceased person's possessions to the relatives in a sensitive and caring manner. The service had blue holdalls that they placed patient's possessions in and gave these to relatives to keep.
- The chaplaincy team worked with patients to ensure their wishes were met for their funerals. Staff provided examples of having living wakes for patients and assisting patients with repatriation requests.

Emotional support

Staff understood the importance of providing emotional support to patients and those close to them.

- The service had a patient and family support team which included the chaplain, a social worker, and three clinical psychologists, one psychologist trainee and a number of volunteers. The service provided psychological and spiritual support for patients, discharge planning as required and post bereavement counselling for their relatives.
- Relatives could attend one on one bereavement sessions with a psychologist or bereavement support groups. One relative that we spoke with told us they had been offered psychological support and found that the nursing staff provided emotional support to them daily.
- One patient told us the emotional support they had received from the service had been "invaluable" and that they had previously been struggling with the process of dying but the psychologist had set their mind at rest.
- The chaplaincy team operated an out of hours on-call service in conjunction with the local hospital, which meant that someone was available to provide support to patients and their relatives 24 hours, seven days a week.
- The complementary therapy team offered a range of therapies to support patients and their relatives including massage and aromatherapy.
- The chaplaincy ran events to support and remember loved ones such as the annual light up a life event and the bi-monthly remembrance and thanksgiving event for relatives who lost a loved one in the last year.
- The service had a pets as therapy (PAT) dog service that attended the inpatient unit and day centre three times a week to allow patients and their relatives to pet dogs to improve wellbeing. The service encouraged patients to bring in their own pets also.
- The day therapy service included the option to take part in wellbeing crafts including conducting life story work with patients which allowed them to create memory boxes, books, video diaries and audio recordings of their lives. The service also provided music therapy sessions with the assistance of a trainee music therapist.
- The service ensured they supported the emotional wellbeing of their staff by providing drop in sessions with the chaplain and holding education sessions such as "wellbeing and self-care for professionals". Staff within the service had access to weekly mindfulness and relaxation sessions as well as reflection sessions run by the chaplaincy team. The community teams had a weekly session called team time in which they discussed how they were feeling that day and identified if any staff needed support.

- The service ensured that sensitive communication took place between staff and patients and their relatives. The chaplaincy service provided education and training to staff to equip them with the skills to aid sensitive communication and promote holistic care.

Understanding and involvement of patients and those close to them

Staff communicated with patients about their care and treatment in a way they could understand.

- Staff involved patients and those close to them in decisions about their care and treatment.
- The service had open visiting times which gave relatives the flexibility to visit whenever they wanted and stay as long as they liked.
- We saw evidence in patient care records that staff were involved decisions about patients' care and treatment and in developing their care plans. Patients and their relatives told us that staff answered questions about care and treatment openly and the information provided to them was clear. We observed the community nursing staff involving and engaging patients and their relatives in discussions about care planning.
- Staff supported patients to make advanced decisions about their care. The day therapy clinical nurse specialist provided patients with support and information about their options for care, and had conversations with patients about their preferred place of care.
- Staff could access courses to ensure that sensitive information was communicated effectively to patients.

Are hospices for adults services responsive to people's needs? (for example, to feedback?)

Outstanding ☆

We had not rated this service before. We rated responsive as **outstanding.**

Service delivery to meet the needs of local people

The service was proactive in meeting the needs of people from their whole community. The services provided reflected the needs of the population served and ensured flexibility, choice and continuity of care.

- The service had engaged actively with different faith groups in the local community and had a group that met to look at how to reach different groups within the community. The service's chaplain undertook a recent talk at a local mosque and invited the mosque's Imam to the hospice. The service had met with the local Jewish Cultural Society to give a presentation on the work of the hospice and invite any questions. The chief executive of the hospice had spoken at a local Diwali celebration about the work the hospice does.
- The service reported good relationships with the traveller community and could provide an example of when a patient from the traveller community had stayed with them and how they had accommodated a greater number of relatives to stay with the patient.
- The service engaged with the local homeless shelter and had invited a representative of a local homeless charity to give a talk to hospice staff.
- The education team had presented to the senior team on raising awareness of potential issues for lesbian, gay, bisexual, transgender, questioning (LGBTQ) patients and staff. The education team planned to roll out this training to all staff within the organisation. Staff that we spoke with could identify potential issues for LGBTQ patients accessing services.
- The service had a multi-faith quiet space that held services and prayers as well as being available for patients, relatives and the public if they wished to use it as a space for reflection.
- The service had participated in a project with the local children's hospice to develop social activities for patent's transitioning from children to adult services. The service had participated in the first of these planned social events which was a pizza social, with other events such as money management educational sessions planned.
- The facilities and premises were appropriate for the services delivered. The design of the inpatient unit and hospice building had been created with the needs of

patients and their relatives at the forefront of planning. During the design phase of the hospice they had held focus groups with patients and the community and were told that some patients wanted the opportunity to be with other patients when staying on the inpatient unit. The service then designed the inpatient unit to have both private rooms and two four-bedded bays to allow patients the choice on the environment they stayed in. In addition to this the service had created a quiet room beside the reception and fundraising office as they observed that patient's relatives often could become emotional when visiting the hospice after a loved one had passed away and the room allowed them time to reflect alone or speak with staff in a private setting. The service had a room designed and furnished to accommodate patients that needed bariatric facilities.

- The service had a range of on-site accommodation and facilities, which families could use including two self-contained apartments with kitchen, bathroom and bedroom facilities, rooms with sofa beds on the inpatient unit and the option of staying in the rooms with patients. Families were encouraged to use the communal kitchen areas to prepare beverages and could eat with their relatives by ordering meals from the services canteen. The service also had access to a range of toiletries for patients and their families to use.
- The service had identified where people's needs and choices were not being met and used this information to inform how services were improved and developed. The service had conducted a project to see where demand lay for a hospice at home service and found that patients and their families needed the most assistance during the night. The service therefore introduced a hospice at home team that worked from 10pm until 7am providing respite, personal care and support to patients and their families. The service monitored where demand in the community was not being met and used this information to apply for additional funding and develop services.
- The service had projects in place to improve end of life care in the community and to access patients that wouldn't usually access their services by providing teaching and education on end of life care to care homes and to other healthcare professionals through the education centre.
- The service had arrangements in place to access translation services for patients. Staff we spoke with could tell us how they would access these services and provided examples of occasions that they had done so.

Meeting people's individual needs

The service took account of patients' individual needs. We saw that care plans and services provided were person-centred and took a holistic approach to patient care.

- We reviewed care plans and saw that services were coordinated with other agencies to provide care to patients with more complex needs. Staff could give examples of when they had referred patients to community mental health services and speech and language therapy teams.
- The service had created a document called the "Getting to know me document" which was given to patients or their representatives to complete to help staff understand what was important to that person. This included information such as a patient's mobility, personal care preferences, eating and drinking habits, social history, communication needs and whether they had any sensory loss. The document was completed in six of the seven sets of patient records we reviewed.
- Staff had received training on working with patients with specific needs such as those living with dementia. The service had recently employed an Admiral nurse for dementia care to provide advice and support to staff caring for patients with dementia. The Admiral nurse also carried a caseload of complex patients and was in the process of developing a dementia-specific day therapy service.
- The service focussed on individual needs and goals in planning patents care at the day therapy centre. Patients goals would be identified and a plan put in place to achieve the goals. For example, patients could want to achieve the goal of tackling their breathlessness so a care plan which involved additional physiotherapy and specialist gym exercises would be put into place. Other goals might involve

advance care planning and therefore appointments with the clinical nurse specialist to have discussions around advanced decisions, emergency decisions and preferred places of care would be arranged.

- Staff monitored and reviewed the changing needs of patients through regular 'comfort rounds' and frequent medical reviews.
- The service had a complementary therapy team who offered a range of therapies to both patients and relatives including aromatherapy, massage and reiki. The service also provided onsite hairdressing and nail technician appointments to patients on the inpatient unit free of charge.
- The service ran a programme of education that focussed on providing individualised care to patients. Sessions included assessing the needs of the "whole person", priorities for the dying patients and their carers and end of life care across the faiths.
- A variety of leaflets were available on the inpatient unit including information about the last days of life. The leaflets stated had different languages on the back explaining that the leaflets were available in different languages and email and telephone details to have them printed and sent. The leaflets were also available in different formats such as large print or on audio tape for those with a sensory impairment.

Access and flow

Patients could access the services they needed.

- The service had effective processes in place to manage admission to the service. The service used one referral form for all its service which was integrated with the local hospital. The service had a central admissions team who monitored and forwarded admissions to the appropriate service. Referrals came through from the local hospital, GP's and the community palliative care teams.
- The service had nine nurse-led end of life care beds that were commissioned by the local hospital. A member of the nursing team attended the local hospital daily to meet with the hospital end of life care team to discuss which patients were suitable to be transferred to the hospice for end of life care treatment.
- The service was working alongside the hospital to improve occupancy rates of their nurse-led beds as they had identified a trend with late referrals meaning that patients could not be transferred to the hospice. The service was developing a pilot project to have a specialist palliative care nurse from the hospice working in the hospital to improve in reach into to the hospital.
- The service's hospice at home night service received referrals directly from the GP and district nurses. The service ensured that a member of staff was available to respond to any urgent referrals on the same day.
- The service monitored referral and admission rates for its services as part of the clinical dashboard which was reviewed at the clinical care board. We reviewed the dashboard for November 2018 and saw that there was no waiting list for lymphoedema outpatient clinics or the inpatient unit. There was a waiting group for day therapy services, however staff told us that patients do not have to wait for more than three weeks post assessment to start a day therapy course. The hospice at home service had contacted 99.2% of patients before the end of the day after a referral was received.
- The service monitored episodes of unmet care and unmet need for the hospice at home service as part of the clinical dashboard. We saw that in the October 2018 there was an unmet need of 36% of episodes of care. The service was aware of this unmet need and was exploring options with the clinical commissioning group (CCG) in how they could address the shortfall.
- The service monitored did not attend (DNA) rates for day therapy as part of their clinical dashboard. We saw that rates for do not attend were 32% for the social and complex groups. The service provided explanation for the rates in that patients often did not attend due to patient illness.
- The service had plans in place to develop text alerts to send to patients attending the lymphoedema Clinic to improve DNA rates.
- The service had a social worker who worked alongside nursing and medical staff on the inpatient unit to facilitate appropriate discharges for patients.
- Patients preferred place of care and preferred place of death was recorded in the patient notes and formed

part of the advance care planning section of patient notes. The service assessed the number of patients achieving their preferred place of death as part of their clinical dashboard. The November 2018 dashboard demonstrated that 96% of patients achieved their preferred place of death in the previous 12 months.

Learning from complaints and concerns

There were clear processes for staff to manage complaints and concerns and all staff were actively engaged with the complaint process.

- Patients and their relatives were supported and encouraged to make complaints where appropriate. Patients were given a leaflet explaining how they can provide feedback or make a complaint as part of their admission. We observed that posters were displayed on the inpatient explaining to patients and their relatives how to make a complaint.
- From1 September 2017 to 31 August 2018, the service received six formal complaints. All six of the complaints were resolved within the target completion date of 30 days.
- The service had a process in place for capturing and learning from negative feedback which was not submitted as a complaint. The service captured this feedback as "concerns" and monitored and discussed both concerns and formal complaints as part of the dashboard and clinical care board meetings. We saw that solutions to concerns were discussed and agreed actions were assigned to members of staff.
- The service promoted learning from complaints by engaging staff in the process. Staff provided an example of a complaint where a relative did not want staff to tell a patient what was happening to them as it was causing distress. The service discussed the complaint with the team involved and asked for ideas from the team of what they could learn from the complaint. Complaints were also discussed as part of team meetings.

Are hospices for adults services well-led?

Good

We had not rated this service before. We rated well led as **good.**

Leadership

Service leaders had the capacity and capability to deliver high-quality, sustainable care.

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. The service was overseen by a board of trustees led by the chair. The senior leadership team was made up of the chief executive officer (CEO), Director of Clinical Services, Director of Fundraising and Communications, Medical Director and Head of HR.
- Leaders within the service went out of their way to ensure that they were visible and approachable. Staff told us that leaders from all levels within the organisation were approachable and supportive and that members of the senior leadership team could be seen regularly on the inpatient unit and would offer support if the unit was busy.
- Trustees held a programme of engagement to ensure strong relationships with staff and visibility throughout the organisation. Since September 2018 the trustees had attended informal lunches on the IPU, wellbeing sessions on the day therapy unit, team meetings and attended staff safeguarding training.
- Leaders within the organisation understood the challenges to quality and sustainability and could provide their intended actions to address these concerns. For example, senior staff were aware of the hospice's unmet need for hospice at home services and the funding challenges that surrounded this. The service leads were looking into different funding options including charitable grants to try and increase this service.
- The service had effective succession planning in place for both the executive team and trustees. The service was in the process of recruiting a new CEO at the time of our inspection and we saw that trustee succession

planning had been discussed at the trustee October 2018 away day and that a succession plan had been discussed by the executive team in June 2018 that included actions and target dates.

- Staff felt connected to other teams within the service and the organisation as a whole. The community nursing team told us they worked well with teams from the inpatient unit and hospice at home.

Vision and strategy

There was a clear vision and credible strategy to deliver high-quality sustainable care.

- The service had an operational plan which encompassed all its services and aligned with their five-year strategy. The service had sought the views of patients and staff when creating the strategy and endeavoured to align the plan with Hospice UK guidance, national strategy and the local sustainability and transformation partnership for end of life care.
- The plan was discussed and its progress monitored in the clinical care board meetings. The executive team reported on the progress of the plan to the trustees on a quarterly basis. We reviewed the updates and saw the service was tracking progress made against the plan and demonstrating actions taken to help them achieve their goals.
- The services objectives and plans were achievable and flexible. Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and engaging with the wider community to ensure equity of access to care. For example, the service's chief executive officer sat on the Cambridgeshire End of Life Steering group which contributed to the oversight and development of end of life care services across the region.

Culture

Managers across the service promoted a positive culture that supported and valued staff.

- All staff we spoke with were positive about working for the hospice. They described feeling valued and supported in their role. Staff who worked remotely said they felt connected to the team and to the organisation.
- There was a recognition of the importance of ensuring patients received a good end of life care experience across all staff groups and services. Staff were engaged with the hospice and proud of the care and treatment they provided for patients.
- The service valued the contribution of its volunteers and had created a touching thank you video showing the work the hospice did whilst thanking volunteers for their contributions. This was shown at the business board on the day of our inspection and subsequently shared on the service's website and social media.
- The culture of the service encouraged openness and honesty. We reviewed incident and investigation reports and saw that the service applied duty of candour appropriately. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke to were aware of the term and could give examples of when the duty of candour would be applied.
- The service had a whistleblowing policy which was available to all staff. Staff we spoke with were aware of the policy and how to raise concerns.
- There was a focus on safety for staff working in the community. The service risk assessed patient visits, had a lone worker policy and equipped community staff with personal safety alarms.

Governance, risk management and quality management

There were clear responsibilities, roles and systems of accountability to support good governance and management. There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. However, we were not assured that the processes and systems in place to monitor equipment were robust.

- The service had a strong governance structure that supported the feed of information from frontline staff to senior managers and trustees. The hospice held bi-monthly team meetings. These meetings in turn fed into the service's monthly care boards. The monthly

care boards rotated between the business care board which focused on the financial aspects of the service and the clinical care board which focussed on clinical governance within the service. The board meetings were attended by senior members of staff in the organisation including the service leads, head of governance and head of finance. The hospice's clinical care board was chaired by the director of clinical services.

- The business and care board meetings fed into the quarterly trustee meetings. The trustee meeting discussed the services quality dashboard, incidents, risks and finance reports.
- Both the trustee meetings and care board meetings discussed the service's monthly quality dashboard. The dashboard looked at mandatory training rates, hand hygiene audits, bed occupancy and referral rates, patient feedback, information governance and quality assessment tool reporting. However, the dashboard did not contain all the outcome data that the service collected including the Hospice UK benchmarking tool data, the NHS safety thermometer and the service's Outcome Assessment and Complexity Collaborative (OACC) measures. These outcomes, whilst collected and monitored by leads within the service, were not all routinely reported on to the care board or trustee meetings and therefore could not shape and improve services. Service leads told us they were working to improve the quality measures reported on the services quality dashboard.
- The service also held clinical governance meetings chaired by the trustee nominated governance lead.
- Feedback from people who used the services and those close to them was regularly discussed at both care board meetings as part of the dashboard review. The service looked at compliments received, complaints and any concerns that had arisen through patients and their relatives. Concerns were discussed by the board and actions identified and assigned to senior staff members.
- There were clear lines of accountability in the service. The service had nominated leads in areas such as safeguarding and infection prevention and control. These leads reported on these areas during care board meetings.
- The service understood its key risks and had oversight of them. The service kept a risk register, which was up to date and staff knew how to escalate any concerns. The risks on the risk register reflected the risks staff had told us about throughout our inspection. For example, recruitment of experienced registered nurses.
- Mitigation was in place for the risks and identified staff who were responsible for providing updates to the business care board on progress made towards managing or removing the risk. There was evidence that the risks were being reviewed and updated regularly. The risks that were on the register had control measures in place and a review date.
- The service had plans in place to ensure continuity of care in the event of an emergency through services emergency plan which could be located on the service's intranet. Staff were aware of the plan and had received training on example emergency situations.
- We were not assured that there was sufficient oversight of equipment in place. We found consumables that were past their expiry date and staff told us that they were not sure who held the responsibility for ensuring that equipment was serviced. There was no overall process or checks in place to monitor equipment at a senior level in the organisation. We fed this back to the senior managers in the services on our inspection and received assurances that processes would be devised to ensure the servicing of electrical equipment and the oversight of expiry dates on consumable equipment.

Engagement

Staff, volunteers and patients were engaged in the service, improving the care and treatment delivered.

- The service engaged well with patients, staff, volunteers and the public and local organisations to plan and manage appropriate services and collaborated with partner agencies effectively.
- The service collected feedback from patients and their relatives in many ways. The community and inpatient teams provided feedback forms in the information packs they provided and the service had a patient user group who undertook telephone interviews to collate

feedback about the service. The service monitored patient satisfaction survey results as part of their dashboard and fed this information back to the care board and trustee meetings.

- The hospice could provide examples of where services had been improved and changed because of the views and experiences of people using the service. Examples included changing when support and counselling was offered to bereaved families from six weeks after the death to providing this information at the final meeting at the hospice or in the community. This was changed following feedback that relatives would have liked support earlier in the process. Another example was where feedback was provided by patients that they didn't want to stop coming to the day hospice after the 10 to 12-week programme. Following this, the service introduced a social group which did not require the same level of nursing or therapy input to enable patients to continue to attend the hospice.
- The service engaged and supported its volunteers. The service sent a survey to volunteers that asked them about their experience working as a volunteer, the recruitment process and support they had received in their role. The responses to the survey were largely positive. The service also held volunteer forums quarterly to gain feedback from volunteers and held monthly volunteer social gatherings in the service's canteen.
- The hospice was proactive in improving services in response to feedback from volunteers. Staff provided the example that volunteers had requested more support with communication and bereavement support for families. As a result, the service organised training with the chaplain on communication and difficult conversations.
- We saw examples of positive engagement with the local community including Arthur's shed which was a project where patients and the community were invited to attend craft and wellbeing sessions.
- Staff were engaged in the planning and delivery of the service. Staff attended regular team meetings to share ideas, opinions and feedback their concerns. The service held quarterly staff forums to update the team on changes and give staff the opportunity to input into the service.
- Employees completed an annual staff survey. The results of the survey were largely positive with staff answering positively to questions asking if they were proud and satisfied to work for the organisation. However, the survey had identified some concerns with bullying in the organisation by 17% of staff. The service leads were proactive in addressing these concerns and were looking into creating another questionnaire to provide assurances. Staff we spoke with on inspection told us that they did not feel bullied and said there had been some historical issues with bullying from staff members that no longer worked for the organisation.

Learning, continuous improvement and innovation

There were systems in place to improve services by learning, continuous improvement and innovation.

- The service was committed to improving services by learning from when things went well or not so well and promoted training and innovation.
- The service was proactive in seeking feedback from staff, volunteers and patients and could provide multiple examples of where service improvements had been implemented as the result of this engagement.
- The service worked together with the Gold Standards Framework (GSF) to deliver the GSF programme to services in East Anglia. The GSF helps doctors, nurses and care assistants provide the highest possible standard of care for all patients who may be in the last years of life. It does this by providing health and social care professionals with the training they need to provide co-ordinated, joined up care. The hospice was the regional centre for the GSF and delivered training programmes and workshops across the organisation and to care homes within the region to enable them to apply for accreditation.
- The service was committed to ensuring that those who are diagnosed with dementia received the best possible care. The service was one of only seven hospices in the UK to employ an Admiral Nurse. Admiral nurses are trained dementia specialist nurses. The Admiral nurse conducted training and research alongside working clinically to ensure that each patient's care programme was tailored to address their particular needs.

Outstanding practice and areas for improvement

Outstanding practice

- The service took a proactive approach to understanding the needs and preferences of different groups of people to deliver care in a way which was accessible and promoted equality. The service engaged with multiple different faiths in the community and seldom heard groups such as the homeless to ensure access to services for all patients.
- Staff in the service demonstrated compassion and dedication to finding innovative ways to support patients with their end of life care. Staff and patients could provide many examples of how the service had ensured patients received care individualised to their holistic needs.
- People's individual needs and preferences were central to the delivery of tailored services. The day therapy service focussed on what patient's goals were for their treatment and how they could improve all aspects of patient's wellbeing.
- Staff within the service completed comprehensive and holistic end of life care plans. The care planning within the service focussed on all elements of the patients care including their spiritual and emotional needs.
- The hospice used engagement with staff, volunteers and patients to shape the services provided. Staff and patient feedback was collected in multiple ways and staff could provide many examples of services being planned and improved as a result of feedback.
- The service had conducted a project to reduce the number of falls experienced by patients. The involved detailed assessments of the causes and frequency of patient falls and innovative solutions to reduce falls.
- The service used innovative ways to look into complaints and improve their services. The service involved staff at all levels in the complaints process and used staff engagement to think of how learning could be identified from complaints.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that effective processes are in place to monitor the servicing and expiry date of equipment.
- The provider should ensure all its policies are up to date.
- The provider should have a process in place to report all outcome measures to its clinical governance meetings.
- The provider should improve mandatory training rates in infection prevention and control.
- The provider should ensure that all volunteers who have patient contact have a DBS check.
- The provider should ensure that falls reassessments are completed in line with policy.