

St Christopher's Hospice

Quality Report

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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?

Outstanding 

Are services caring?

Good 

Are services responsive?

Outstanding 

Are services well-led?

Outstanding 

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

St Christopher's Hospice is operated by St Christophers Hospice. It has 38 beds and provides hospice care for adults including inpatient care, outpatient clinics and community services. We inspected all of these areas.

We inspected this hospice using our comprehensive inspection methodology and carried out the unannounced inspection on 11th and 12th December 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: 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 the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided by this hospice is palliative care and care of the dying.

Services we rate

Our rating of this hospice stayed the same. We rated it as **Outstanding** overall, because:

- Staff and volunteers proactively kept patients safe from avoidable harm and abuse. Staff regularly completed thorough risk assessments to tailor care.
- Patient care was accurately recorded, and these records were available to staff when required including to consultants off site when on call.
- Staff and volunteers had appropriate training to care for patients. Training needs were regularly assessed, and staff told us they were able to access learning to improve the level of care they were able to offer.

- Services were designed to meet patients changing, and often complex, needs.
- Staff cared for patients with compassion and treated them with dignity and respect. Staff saw each patient as an individual and involved them in decisions about their care goals.
- The hospice had a range of bereavement support to allow relatives and carers to access the support they needed.
- The hospice actively reached out to groups that were hard to reach, to enable them to use their services.
- There were clear processes for recording and responding to complaint and concerns, these had been strengthened in the past year.
- Leaders had the skills and abilities to run the hospice and were passionate about the care they delivered. They were aware of the potential risks facing the service and planned to minimise these risks.
- Staff were engaged with the service and told us there was an open, honest and caring culture.
- The hospice actively involved patients and staff in decisions about changes to services.
- The hospice had a clear vision of what it wanted to achieve and a strategy to make this happen.

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

- The infection control policy, after death, was not fully being adhered to, therefore potentially putting staff at risk.

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South)

Summary of findings

Our judgements about each of the main services

Service

Hospice services for adults

Rating

Outstanding



Summary of each main service

St Christopher's Hospice provides care for patients in Bromley, Southwark, Lewisham and Lambeth and Croydon. It has a main inpatient and outpatient base in Sydenham, with some staff working from the Bromley site. The service also has a large community branch to provide specialist care in the community. We rated the hospice as outstanding overall as it was good for safe, and caring and outstanding for effective, responsive and well led.

Summary of findings

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Outstanding



St Christopher's Hospice

Services we looked at:

Hospice services for adults.

Summary of this inspection

Background to St Christopher's Hospice

St Christopher's Hospice is operated by St Christophers Hospice. The hospice opened in 1967 and is based in Sydenham. The hospice primarily serves the communities of South London and covers the areas of Southwark, Lewisham, Lambeth, Croydon and Bromley.

The hospice cares for people in their own homes, ran an outpatient service and an inpatient unit, based in Sydenham. It also ran a frailty service and a palliative heart failure service in conjunction with Bromley Clinical Commissioning Group. The hospice also provided services designed to support families and carers including bereavement support, welfare advice and support groups for children or young adults.

The hospice has had a registered manager in post since November 2018. A registered manager is a person who has registered with the Care Quality Commission to manage the service. They have legal responsibility for meeting the requirements set out in the Health and Social Care Act 2008.

The hospice was last inspected in 2015, by our adult social care team, and was rated outstanding overall. We inspected the hospice on 11 and 12 December 2019, our inspection was unannounced.

Our inspection team

The team that inspected the hospice comprised a CQC lead inspector, one other CQC inspector, one CQC

assistant inspector and two specialist advisors with expertise in end of life care. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

Information about St Christopher's Hospice

The hospice has three wards and is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Diagnostic and screening procedures
- Transport services, triage and medical advice provided remotely
- Personal care

During the inspection, we visited Rugby ward, Alex ward and City ward, the outpatient service, visited the staff working from Bromley and attended two home visits with the community team. We spoke with 30 staff including registered nurses, health care assistants, allied health care professionals, medical staff, orderlies, stewards, administration staff and senior managers. We spoke with 12 patients and relatives and volunteers. During our

inspection, we reviewed five sets of electronic patient records. We also reviewed information the hospice sent us prior to inspection and data requested after the inspection.

Activity

In the reporting period September 2018 to August 2019 the hospice cared for 4,480 patients.

The accountable officer for controlled drugs (CDs) was a consultant nurse, who was a non-medical prescriber.

Track record on safety

- No never events
- One serious injury
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),

Summary of this inspection

- No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
 - No incidences of hospital acquired Clostridium difficile (c.diff)
 - No incidences of hospital acquired E-Coli
 - 28 complaints, of which nine were upheld. The hospice also received 477 compliments.
- Services provided at the hospice under service level agreement:**
- Speech and language therapy support.
 - Pharmacy

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?

Our rating of safe stayed the same. We rated it as **Good** because:

- Staff we spoke with understood how to protect patients from abuse. There were systems in place for managing safeguarding referrals and these were managed by the safeguarding lead, in line with current best practice.
- Risk assessments were completed and updated at appropriate intervals.
- There were enough staff, who were suitably qualified and experienced to ensure patients received appropriate care and treatment.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.

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

- The hospice needed to ensure all staff were adhering to the care after death policy with regards to infection prevention control to ensure staff members were kept safe.

Good



Are services effective?

Our rating of effective stayed the same. We rated it as **Outstanding** because:

- The hospice provided care and treatment based on national guidance and evidence-based practice.
- Staff monitored patients regularly and delivered pain relief in a timely way, when required.
- Patient outcomes were monitored and interrogated at quality and governance meetings to ensure the hospice was providing appropriate care and treatment.
- The hospice made sure staff were competent for their roles, providing both internal and external training to facilitate this.

Outstanding



Are services caring?

Our rating of caring stayed the same. We rated it as **Good** because:

- Staff always 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.

Good



Summary of this inspection

- Staff understood the importance of providing emotional support to patients and those close to them and were willing to go ‘the extra mile’ in order to meet their needs.
- Staff truly cared for patients with compassion. Feedback from all patients and those close to them confirmed that staff treated them well and with kindness.

Are services responsive?

Our rating of responsive improved. We rated it as **Outstanding** because:

- The hospice planned services to meet the needs of the communities it served. It was proactive in reaching out to hard to reach groups and tailored care to their needs.
- The hospice was inclusive and took account of patient’s individual needs and preferences. Staff made adjustments to help patients access services and coordinated care with other services and providers.
- People could access the hospice when they needed it and received the right care promptly, the hospice risk assessed referrals to allow emergency admissions to be prioritised.
- The hospice ensured patients knew how to make complaints or raise concerns about the care they received.

Outstanding



Are services well-led?

Our rating of well-led stayed the same. We rated it as **Outstanding** because:

- Leaders had the skills and abilities to run the hospice. They understood and managed the priorities and issues the hospice faced.
- The hospice had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focussed on the sustainability of services.
- Staff felt respected, supported and valued. They were focussed on the needs of patients receiving care. The hospice had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact.
- Leaders and staff actively and openly engaged with patients, staff and the wider community to plan and manage services. They also collaborated with partner organisations to help improve services.





Outstanding








Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Hospice services for adults

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

Are hospice services for adults safe?

Good 

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

Mandatory training

- **The hospice provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Staff received and kept up-to-date with their mandatory training. Staff we spoke with were up to date with all their mandatory training. They told us there were processes in place to remind them when they were due to undertake training, and this was in the form of an email. The email was sent a few months before training was due to lapse which gave staff time to book onto the necessary course. Staff told us they were given time to undertake training once in post and all new staff were enrolled on the corporate induction which covered most mandatory training topics as well as an introduction to the hospice.
- We were told by the volunteer leads that, where necessary, volunteers also attended mandatory training and updates. For example, volunteers supporting the inpatient unit undertook safeguarding training and some would undertake communication training, if applicable.
- The mandatory training was comprehensive and met the needs of patients and staff. Staff told us they felt the mandatory training was appropriate and enabled

them to do their jobs safely. Mandatory training topics for clinical staff included safeguarding, Mental Capacity Act, Deprivation of Liberty Safeguards, manual handling and infection control.

- Managers monitored mandatory training and alerted staff when they needed to update their training. We were told there was a database of staff mandatory training numbers and this was used to email staff when they were due to undertake training. Although managers would have oversight of their staff's training it was the staff members responsibility to get the training arranged. This was a topic of conversation at annual appraisals.
- The hospice's induction programme was comprehensive and prior to staff being employed by the hospice IT access and email accounts were set up. This enabled staff to access e-learning from the beginning of their employment.

Safeguarding

- **Staff understood how to protect patients from abuse and the hospice worked well with other agencies to do so. Staff had training on how to recognise and report abuse, they knew how to apply it and could provide examples of when they had applied it.**
- Staff received training specific for their role on how to recognise and report abuse. Staff told us they received and were up to date with their safeguarding training and that they found it informative. We were told that 92% of staff requiring adult safeguarding level one training were up to date and 89% of staff requiring level two training were up to date. Staff told us that



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alongside the training, if they were concerned about anything they could refer to the safeguarding policy on the intranet and felt they could always approach the safeguarding lead for support.

- Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could give examples of setting up best interest meetings to discuss patients and their relatives needs with other agencies. Best interest meetings were aimed at making decisions for people who lack the capacity to do so any more and often involve other agencies to ensure care is cohesive between agencies.
- Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could explain the safeguarding referral process and give examples of when they had needed to make referrals. We were told a large proportion of safeguarding referrals were concerning care of dependents following a bereavement. The hospice made these referrals before the patient died to ensure their wishes could be included in the ongoing care plans for dependents.
- Clinical staff told us safeguarding referrals could sometimes be complex, particularly when the patient lived in one local authority, but ongoing care needs were identified to be needed in another local authority. The safeguarding lead confirmed that this was the type of case they would support and guide staff through.
- Although the hospice was for the care of adults, staff and volunteers undertook child safeguarding training to enable them to notice if a child was at risk and to be able to act upon this information in an appropriate manner. We were told that 100% of staff needed it were up to date with their safeguarding children level three training.

Cleanliness, infection control and hygiene

- **Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Staff used infection control measures when visiting patients on wards.**

- Ward areas were clean and had suitable furnishings which well-maintained. We observed cleaning rotas were completed and signed by staff and the environment was visibly clean with no dust settled on surfaces.
- There was a rolling replacement and repair programme for recliner chairs on the ward to ensure they remained intact and able to be effectively cleaned when required.
- The hospice also conducted monthly mattress audits to assess the appropriateness of the mattresses in use and to highlight if any required disposal or decontamination. This was in addition to clinical staff visually checking at linen changes. The hospice had an outsourced contract with a cleaning company to decontaminate any mattresses that required thorough decontamination.
- Clinical staff told us they were supported to keep the environment clean by a team of orderlies. There were two orderlies per ward and two assigned to the ground floor communal areas each day. In the evening, when there were fewer visitors to the hospice, there was one orderly assigned to each ward and the ground floor. This enabled thorough cleaning of the environment and flexibility if deep cleans were required if infection control risks were highlighted.
- Staff followed infection prevention and control (IPC) principles including the use of personal protective equipment (PPE). We observed all clinical staff followed bare below the elbow principles and appropriately cleaned their hands before and after patient contact. We also observed appropriate use of PPE when required.
- The adherence to IPC principles was proven to be effective as the hospice had no incidents of colostrum difficile (C Diff), MRSA or vomiting or diarrhoea outbreaks in the year leading up to the inspection.
- One steward told us they were not routinely informed of potentially infection risks when they transferred deceased patients to the mortuary. We raised this with hospice managers while on inspection and were told that processes would be reviewed. Since inspection we have been sent the hospice's 'care after death policy' and the paperwork to be completed mentioned in the policy. This documentation clearly



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outlines the procedures to follow if a patient's body could pose an infection risk. The hospice has clarified they will reiterate and, where necessary, retrain staff in this policy to ensure safe procedures are followed.

- Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw thorough use of "I am clean" labels on the wards and throughout the wider hospice environment. The "I am clean" labels were all dated and signed to enable staff to identify when the equipment had last been cleaned and if it required another clean before use.
- The hospice generally performed well for cleanliness. The hospice produced an annual infection prevention report, in addition to the more frequent hand hygiene audits. The annual infection prevention report collated all the smaller audits and looked for themes and areas that required improvements over the coming year. The infection control audit, carried out by a matron of a nearby trust, found the hospice to be 100% compliant with standards set by the department of health and was scored using the infection control nurse's association audit for monitoring infection control standards.
- The hospice was peer reviewed for compliance with IPC guidelines by an infection prevention and control matron from a nearby trust in March 2019 and all areas including the mortuary was found to be fully compliant.
- All clinical areas had hand washing facilities and there was access to hand sanitiser throughout the hospice. In all clinical areas we checked there were disposable sanitising wipes available to ensure surfaces could be cleaned.
- The hospice completed regular water testing for legionella and bacteriological infections and prioritised high-risk areas to have more regular inspections. There was a policy in place to action any positive results that may occur, this policy included notifying external agencies.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**
- The design of the environment followed national guidance. The environment followed national guidance, with flooring that was easily cleaned, handwashing sinks in clinical areas and single rooms all had private bathroom facilities. All corridors were wide enough to fit a bed and wheel chair down and followed fire safety recommendations. We noted all fire doors were closed, where not on automatic closure mechanisms.
- In the wider hospice environment we found all patient toilets had pull cords, which reached to the ground in case a patient fell.
- We found one consultation room in the outpatient environment that did not have a call bell in, this was known to the hospice and the risk was mitigated as we were told patients would not be left alone in the room.
- The hospice was set over four floors and there were accessible lifts, which were regularly serviced. In addition to the patient lifts there was a staff lift which was situated near the mortuary. This lift could be overridden to bypass other staff calls to allow patients to be transferred from the wards to the mortuary in a dignified manner. The lift override process was included in the hospice 'care after death' policy.
- The mortuary followed national guidance and was visibly clean. There was lifting equipment which enabled stewards to safely move deceased patients into fridges or into viewing rooms. There was space for 18 patients, with capacity to take bariatric patients.
- The hospice design had taken into patient's individual needs into account. For example, the garden had pathways that were paved and wide enough for patient beds to be taken outside. This was to allow bed bound patients to experience the gardens if they wished. They also had complementary therapy rooms set up for massages and a hair dressing salon on site for patients to use.
- The hospice had suitable facilities to meet the needs of patients' families. Each ward had dedicated space for families to sit separate to patients should they



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need space. These spaces had computers and games to play if families were on site for an extended period and could also function as an area to have private discussions

- The hospice had enough suitable equipment to help them to safely care for patients.
- Staff told us they had not experienced not being able to access equipment they needed. The hospice kept a log of all equipment and medical devices and had a contract with an external company to loan equipment when repairs were required. We were told that when medical devices faulted the hospice reported these faults to the Medicines and Healthcare products Regulatory Agency (MHRA).
- Staff disposed of clinical waste safely. We observed all clinical waste to be disposed of safely and in appropriate bins. These were routinely changed by orderlies and taken to the bin store for collection. In the community setting nurses took sharps bins out with them to allow for safe disposal of equipment if needed.
- The head of facilities confirmed the hospice had a computerised maintenance system to log all jobs which required action and to plan routine servicing and maintenance. The head of facilities confirmed the hospice had backup generators that were regularly tested and serviced by an external contractor. They also confirmed the hospice carried out regular fire risk assessments with an external agency to ensure unbiased assessments were completed. While on inspection we saw additional signage being added to fire doors following one of these assessments. Following the inspection we were sent a copy of one of the surveys and the associated action plan.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.**
- Staff completed risk assessments for each patient on admission and updated them when necessary and used recognised tools. These risk assessments included falls risk, skin and wound assessments and

moving and handling needs, nutrition, swallow and pain assessments. Some of these were completed by specialist allied health professionals for example the swallow assessment was completed by a speech and language therapist. All risk assessments were kept as part of the patient's electronic record and were updated as required.

- All patients, including outpatients and community patients, were assessed for their suitability to receive cardiopulmonary resuscitation (CPR). We observed a thorough discussion with a new patient to the hospice about their decision to receive CPR or not. We observed that patients who were assessed to be too unwell to receive CPR had 'do not attempt CPR' forms in their care records. This was mirrored in the co-ordinate my care system so other healthcare providers were able to access the form.
- Staff knew about and dealt with any specific risk issues. At ward rounds, staff demonstrated clear knowledge of patients' care needs and any specific risks facing them. If a patient was refusing an element of care which was likely to increase a risk to them, such as turning to reduce the risk of pressure sores, this was discussed along with the steps the staff had taken to encourage the patient to allow care and whether the patient had the capacity to make these decisions.
- Staff also discussed how to minimise any risks facing patients, such as physiotherapy and occupational therapy input to help mobilise patients safely and dietician and speech and language support to enable safe feeding on a suitable diet. These additional needs were logged and added to the patient record.
- At the community multidisciplinary meeting we heard risks being discussed before staff went out to people's homes or to care homes. This meant plans to mitigate these risks were discussed prior to staff going out and the staff member was aware of any concerns before entering the patient's home.
- Staff shared key information to keep patients safe when handing over their care to others. When patients were discharged from the inpatient unit we saw thorough discharge plans which were shared, with the



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patient's permission, with other care agencies such as a care home or the patient's GP or district nurse. This allowed connected care and for gaps in care provided to be kept to a minimum.

- Within the hospice there was communication between the inpatient unit and community teams when a patient was discharged home. This meant the community team were aware they would need to add the patient back onto their case load for review.
- Shift changes and handovers included all necessary key information to keep patients safe. We observed a shift handover and noted all of the patient's medical, social and psychological conditions were handed over ensuring a holistic approach to care. Staff did not only discuss the patients' physical health but also their social and psychological needs as well. There was also discussion about family support at these handovers, considering all elements that would be important to a patient.

Clinical staffing

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

- The hospice had enough nursing staff and support staff to keep patients safe. We were told the model was to have 60:40 split on each shift in the inpatient setting between registered nurses and health care assistants. The planned number of nurses on each shift was 3 in the day and 2 on each ward overnight. In addition to this there was a supernumerary nurse and health care assistant based at the inpatient unit overnight. The extra members of staff on the night shift were allocated to undertake any emergency community visits that were identified by the night co-ordinator, this meant wards were not left short staffed overnight if a community visit was needed. Nursing staff told us they felt staffing levels were appropriate, and they had time to deliver compassionate care.

- Community staff told us their staffing levels allowed for manageable caseloads, and this was set to improve when the recently recruited members of staff joined the team. Caseloads were not set by the number of patients a staff member was seeing but by how complex their needs were and how frequently they needed contact with the hospice. The hospice had an assessment system for monitoring patient's needs and grading them to decide the frequency of visits.
- Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. We were told the current nurse staffing levels on the inpatient unit were calculated approximately three years ago when the hospice did observational studies to work out where nurses and healthcare assistants spent their time and then they compared these with other hospices. This was fed into a workforce planning tool and was monitored by the senior nursing team. We were told the team are looking to repeat the cycle of observational studies and benchmarking again next year (2020) to prove to themselves they are still working safely.
- The ward manager could adjust staffing levels daily according to the needs of patients. The overall nursing team was flexible and could be moved between wards depending on the needs of patients and the complexity of cases. We were told if one ward had several complex patients and another ward had more simple cases the senior nursing staff would be moved for increased oversight of the complex cases and more junior members of the team would be assigned to the simpler cases. This meant there was flexibility in the system to enable staff to care for patients.
- The hospice had low turnover and vacancy rates. The community team was due to be fully staffed in mid-December, with new members of staff joining the team. The inpatient unit was nearly fully staffed at the time of inspection, with three nurse posts outstanding.
- The hospice had low sickness rates. The nursing and allied health professional sickness rate was low at 4.1%, with health care assistants slightly higher at 5%.
- The hospice had low usage of bank or agency staff and preferentially used bank staff as they knew the hospice



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already. We were told some of the nurses on the hospice's bank were retired nurses who had worked for them previously. Agency usage was done sparingly when needed clinically.

- The number of allied health professionals was calculated to enable specialist support when needed on the wards. We were told by members of the allied health professional team that their workload was manageable, and they were able to have input into patient case management to enable them to be cared for safely.
- The hospice had developed a document to identify different categories of volunteers and within that to identify appropriate checks, for example DBS, and training requirements. Volunteers were invited, and required, to attend applicable parts of the staff corporate induction to ensure that, where necessary, they received the same training as staff.

Medical staffing

- **The hospice had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.**
- The hospice had low turnover and vacancy rates for medical staff. The hospice employed five consultants and consultant turnover was low and there were no vacancies. There was a higher rate of turnover for more junior members of the medical team, this was explained as junior doctors rotated more frequently in order to gain experience in more areas of clinical practice.
- Sickness rates for medical staff were low. Sickness rates in the reporting period of June to August 2019 were very low at 0.2%.
- The hospice had a good skill mix of medical staff on each shift and reviewed this regularly. There was medical cover seven days a week and the inpatient unit had a specialist registrar assigned to each ward. Consultants were not assigned to specific wards in the

inpatient setting but were available to cover and support more complex cases, these were discussed and decided at the morning ward rounds, or if a patient's condition changed in the day.

- The hospice had a review of consultant roles planned to take place in 2020 to ensure they were being used in an effective way.
- Patients were not always under the care of a specific consultant, however consultants were involved in the daily ward rounds and so had oversight of all patients on the inpatient unit and were contacted if a patient's needs increased in complexity and more senior input was needed. This was formally done through the electronic record, there was a section for "consultant input required" where the needs could be explained.
- The hospice had access to locum staff when required. These locum doctors were known to the hospice and were often trainee GPs from the local area who had links with the hospice. This flexibility meant the hospice was able to maintain a safe level of medical cover.
- The hospice always had a consultant on call during evenings and weekends. We were told there was always a consultant on call to provide support for staff should they need it. These consultants had remote access to the electronic patient records so could access all the pertinent information about the patient's condition. The on-call consultant would also make community visits overnight if there were particularly complex patients and the nurses needed support, we were told this was not often needed as the nursing staff and junior doctors were equipped to manage most situations but that they knew it was an option. Staff we spoke to confirmed this and said they would contact the consultant if they felt it was necessary.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**
- Patient notes were comprehensive, and all staff could access them easily. All patient records, apart from drug charts for inpatients, were electronic. This meant staff



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could access patients notes from anywhere on site, and certain staff such as consultants had secure access at home to enable them to give advice while on call.

- Patients had the option to complete a 'One Page Profile' to inform staff about what was important to them and how to best support them. This was completed by the patient or relative and was copied into the patient's electronic record. It enabled staff to personalise their approach to each patient.
- When patients transferred to a new team, there were no delays in staff accessing their records. As all records were electronic and they were instantly available to teams within the hospice. When patients were discharged from the inpatient unit information was put in records to alert the community team of the discharge, so they were aware they would need to start up support for the patient again.
- In addition to the full patient record being electronic the hospice, with patient consent, created a 'co-ordinate my care' record that was available for other healthcare providers. This was a reduced version of the full patient record and held details of the patient's physical condition and symptoms and any advanced care plans, do not attempt cardiopulmonary resuscitation forms or patient preferences. 'Co-ordinate my care' records were available to primary medical care providers such as GPs and district nurses and the aim was to reduce the amount of times a patient had to repeat their care needs.
- Medicine chart records were stored securely. These were kept in the nurse's station on each ward, this was always manned by staff and was therefore secure.

Medicines

- **The hospice used systems and processes to safely prescribe, administer, record and store medicines.**
- Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

- The pharmacy management had been taken over in August 2019 by an acute NHS hospital trust. As part of this process the pharmacy managers were in the process of reviewing and strengthening the medication and prescribing policies and procedures.
- The pharmacy technician attended multidisciplinary meetings to allow them to pick up on potential issues before prescriptions were submitted for filling out. This meant patients with complex needs, who were on many medicines, were routinely discussed with the pharmacist to enable safe prescribing.
- There was a hospice wide prescribers meeting which was attended by medical and non-medical prescribers to allow for open conversation about concerns or any changes to practice. We were told that previously there were two meetings, one for medical staff and one for non-medical prescribers. This was deemed to be a less effective use of time and as such the meetings were merged to allow a full discussion to be held.
- Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.
- Patients and relatives we spoke with told us they understood how to safely take the medication they were prescribed and knew why they were taking it.
- We observed nurses in the community reviewing and altering a patient's medication as their needs had changed. The reasons for this change were then explained to the patient and their relatives and they were told how and when to take the medication for the greatest effect.
- We saw evidence, in care records of inpatients, of medicines being started, reviewed and stopped if they were not effective.
- Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were locked in the pharmacy store on site. And temperature sensitive medicines were stored in a fridge and the temperature was regularly monitored and recorded. Within the pharmacy store there was a separate, secured controlled drugs cupboard. Controlled drugs are drugs that have the potential to alter behaviour or be abused and therefore extra



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security is needed. St Christopher's hospice had an allocated controlled drugs accountable officer, one of their consultant nurses, who was ultimately responsible for the safe storage and prescribing of these drugs.

- The pharmacy store was randomly spot checked for out of date medicines and we found that they were stored appropriately. There were medicines available for use in an emergency and these were regularly checked.
- The hospice used syringe drivers to deliver medication, when required, and nurses received training on their induction to train them to use the hospice's syringe drivers. Syringe drivers were marked as sterile when cleaned and were regularly reviewed throughout shift. Medication doses were discussed at each ward round.
- The hospice had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. There were mechanisms in place to ensure safety alerts about medicines were effectively acted upon. The pharmacy technician at the hospice explained processes to quarantine and send the medicines back to the acute hospital that managed the pharmacy store. The technician explained that this was a proactive process and even if the hospice did not stock the medicines they had to confirm they had none on site. This removed the risk that somebody might wrongly assume they did not stock a medication and miss a safety alert.
- Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We observed a multidisciplinary meeting for community staff where it was discussed if prescriptions for pain relief were appropriate as a slight increase in the amount of pain relief being prescribed had been noticed. As part of this meeting the team also discussed each patient's current pain medication and reviewed whether it was still appropriate or, if the patient needs had changed and therefore the medication was changed.

Incidents

- **The hospice managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers**

investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

- Staff knew what incidents and near misses to report and how to report them. Staff were clear about their duties when it came to reporting incidents and were able to report them using the intranet system. The new reporting system had been brought in as staff felt the old system was not user friendly. The new system was available for all staff to report on and was accessible from the intranet home page.
- Staff reported serious incidents clearly and in line with hospice policy. Staff reported one serious incident, a choking incident, in the reporting period of September 2018 to August 2019. This had been reported in line with hospice policy and was reported to CQC prior to the inspection. The incident had been thoroughly investigated and changes were made to policies and procedures because of learning from the incident. While on inspection staff we spoke with were told us about the changes to protocols and that they were able to contact the dysphagia team should they have any concerns regarding a patient's ability to swallow safely.
- The hospice had no never events on any wards or in the community care setting.
- Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff were able to explain their responsibilities to be open and honest with patients and relatives under duty of candour. In addition to this they told us where to find the hospice "being open; a duty of candour" policy.
- Managers debriefed and supported staff after any serious incident. The documentation we were provided with following the serious incident demonstrated that staff involved had been debriefed and offered ongoing support following the incident. Staff we spoke with while on site knew about the incident and were aware of the changes to policies that had been made.



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- Managers investigated incidents thoroughly. Managers and staff carefully discussed and unpicked incidents considering factors that had played into them and ways to mitigate this in the future. For serious incidents timelines leading up to and following the incident were created to highlight step by step what had been done and how, if possible, this could be improved.
- Staff received feedback from investigation of incidents. Staff were able to detail changes to policies and procedures that had been made because of incident reporting and investigation. Staff were offered the chance to debrief with ward managers if they had to deal with a difficult situation on the ward.
- Staff met to discuss the feedback and look at improvements to patient care. Ward managers and assistant ward managers met to discuss any challenging situations they had come across on their wards and to discuss how they could be managed better in the future. This was then shared with clinical staff working on the wards.

Are hospice services for adults effective? (for example, treatment is effective)

Outstanding



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

Evidence-based care and treatment

- **The hospice provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.**
- Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.
- The medical director worked with a number of government and national working parties to support development of national guidelines published by the Royal College of Physicians and the Association for Palliative Medicine. They also supported government enquiries and worked as an expert advisor for legal cases.
- We saw anticipatory medicines for pain management, breathlessness, nausea, distress and agitation were prescribed. These were given in line with the National Institute of Health and Care Excellence (NICE) guidelines for care of the dying adult in the last days of life and palliative care for adults. The hospice audited the use of these anticipatory medicines to ensure patients were benefitting from them.
- The hospice used a carers' support needs assessment tool to ensure carers needs were also considered and attended to. Following a bereavement, the hospice ran multiple bereavement support groups which targeted different demographics to ensure relatives and carers were supported through the bereavement process.
- The hospice used recognised measures to quantifiably identify whether patient goals and outcomes were being met and potentially improving. The hospice used Integrated Palliative Outcome Score (IPOS) which was a tool to identify patient priorities of care and changes in patient symptoms. The IPOS tool was designed to create a standardised set of outcome measures for use in palliative care and was focussed on promoting a holistic and patient-centred approach.
- The hospice used the Karnofsky Performance Status Scale to standardise its measure of patient's status. The Karnofsky scale is a standardised tool used to measure the ability of a patient to perform day to day tasks. All staff were knowledgeable about the different points on the scale and we saw posters in the nurses' station on each ward as a reminder of what they were.
- Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. All staff we spoke with had a good understanding of the Mental Health Act and could explain how they took to ensure patient's rights were protected.
- At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed patients, relatives and carers holistic needs being thoroughly discussed at ward rounds. Staff discussed potential social worker



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involvement and began planning for post bereavement care. Emphasis was also placed on the spiritual wellbeing of patients and the hospice arranged for religious leaders to attend the hospice if it was a patient's wish to have this happen.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The hospice made adjustments for patients' religious, cultural and other needs.**
- Food and drink were available for patients throughout the day in the in-patient unit, although there were set meal times for full meals. Patient's relatives were permitted to bring in food from home and there were facilities on each ward for them to heat this up, if needed.
- Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it. The inpatient hospice had dieticians and there was a speech and language therapist who was contracted to come into the hospice from a local hospital. On days the speech and language therapist were not available on site to perform swallow assessments staff had a flow chart to follow to ensure patients were being fed and hydrated safely if they were at risk of choking. This chart was available in every ward kitchen and advised ward staff on ways to keep patients safe, staff were aware of where it was.
- As patient relatives were welcome to bring food and drink from home into the inpatient unit staff explained how they communicated the advice of the speech and language therapist and dieticians to the family to ensure patients were not put at unnecessary risk of choking.
- The hospice had a nutrition and dysphagia champion group which was formed of a dietician, link nurses and a speech and language therapist. Dysphagia means difficulty with swallowing. This group meets regularly and regularly review the policies and procedures surrounding nutrition and swallow assessments to ensure they were appropriate and kept patients safe.

- Staff were able to routinely refer patients to dieticians or speech and language therapists for specialist input into a patient's care. Staff were aware of how to access these services and we saw referrals being discussed at ward rounds.
- The hospice had developed a leaflet which summarised the answers to frequently asked questions about 'eating and drinking when ill' to support patients and relatives.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**
- Staff assessed patients' pain and gave pain relief in line with individual needs and best practice. There was an individualised approach to pain relief at the hospice that was patient driven. Some patients preferred to live with some pain to allow them to feel less drowsy and enable communication with family and loved ones. The hospice worked with these patients to balance pain relief with side effects.
- In conjunction with an NHS trust St Christopher's offered indwelling epidural nerve blocks to control pain in patients with complex needs and whose pain was otherwise uncontrolled. Indwelling epidural nerve blocks are a way of controlling pain by blocking nerves, however it is complex to manage and not often seen outside of specialist hospital settings. The hospice ensured senior nurses were trained to manage the epidural sties. We were told although the team from the hospital routinely attended on a Wednesday, they were flexible and came to support on other days if there was a patient who was suffering with uncontrolled pain and the hospice had no other options for managing it.
- Staff prescribed, administered and recorded pain relief accurately. We reviewed drug charts and found them to be completed in full and demonstrated that patients received the correct medication at the right time, unless the patient had refused it.
- The hospice told us patients were asked to keep pain diaries which were then discussed with clinicians



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enable them to best optimise pain control prescriptions. Pain assessment tools were available on the patient's electronic record and included the PAINAD scale, which was a tool to support pain relief in patients with dementia.

Patient outcomes

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

- Outcomes for patients were positive, consistent and met expectations, such as national standards.
- The hospice participated in Hospice UK benchmarking for falls, pressure ulcers and medication incidents. We noticed St Christopher's had a high number of pressure ulcers identified compared to hospices of a similar size and work was on-going into identifying why this was. The hospice was looking at a number of factors including whether they had a particularly frail and therefore immobile population, whether patients attended with pressure ulcers and whether their staff were very good at noting and reporting pressure ulcers therefore the increase in numbers was reflective of good practice. These discussions were not only happening at a local level but also with other hospices in the area to ensure conclusions were valid. The hospice was assured they were caring for patients well and had a tissue viability group who advised on skin care.
- The hospice used the integrated palliative care outcome score (IPOS) to assess their effectiveness for individual patients. These scores were also looked at on a hospice wide level to ensure patients benefitted from inpatient care. These were scrutinised at the quarterly quality and governance meetings and were used as indicators to ensure the changes to the model of care was not negatively impacting on the quality of care and the outcomes for patients. The aim in the future was to use the IPOS "splattergrams" at daily ward rounds and at MDT's to inform patient care and next steps. The "splattergrams" were a graphical representation of the data collected from IPOS assessments.
- The hospice had also implemented the Outcome Assessment and Complexity Collaborative (OACC)

initiative which was aimed at implementing outcome measures in routine palliative care. The coding to enable OACC to be successfully used was in the electronic records therefore clinicians were confident the output was accurate.

- Following inspection the hospice told us they also participated in training other hospices across the UK on how to collect and report on data relating to pain and symptom control management.
- The hospice had designated staff who were responsible for ensuring hospice policies and procedures followed the national guidance. All policies and procedures we saw were within their review dates.
- Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The hospice had an audit register which included all the regular audits that were carried out, how frequently they needed repeating, which member of staff was responsible for them and any outcomes identified at the last audit. For example, the equipment store audit was owned by the medical devices administrator and had no outstanding actions.
- In addition to the audit register staff were empowered to identify and propose new audits and the hospice had audit proposal forms that were assessed by the quality team before being agreed.
- Each year there was a push to get more members of staff involved in the audit processes. The quality team provided training to a multi-professional team, including administration staff, allied health professionals, doctors and nurses and asked them about any concerns about care and to think about ways to improve this. The 2018-2019 cohort identified the change in the case management model as a concern and transfers in care between health agencies as a potential downfall. This was followed through and staff looked at all elements of the discharge process to identify necessary changes, such as how the teams communicated with external agencies. The changes made are being re-audited to ensure they were effective.
- Managers then used information from the audits to improve care and treatment. Audits led to changes in



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practice which were then re-audited for success. Managers shared and made sure staff understood information from the audits. We were told there were a number of mechanisms by which staff were informed of changes. These included team meetings, emails and huddles at the end of shifts.

Competent staff

- **The hospice made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All registered nursing staff were enrolled into a foundation course for palliative end of life care to supplement their knowledge, this was funded by the hospice and staff were given study leave to complete it.
- Health care assistants were given significant training on induction which resulted in them gaining a care certificate. They were also given the opportunity to enrol on professionally recognised palliative care certificate courses at level two and three.
- Medical staff could be part of a weekly journal club to promote ongoing learning and discussion and were able to enrol on external courses if their development plan identified an area of interest that could be developed. The assistant medical director was the lead for medical education and co-ordinated this learning.
- Staff were given training that was relevant for their role and they had competency checks to complete. For example, nurses on the ward were trained and assessed for their competence in how to use the syringe drivers that were used by the hospice and in indwelling epidural care.
- Managers gave all new staff a full induction tailored to their role before they started work. There was an induction for new staff and this was monitored by their line managers. Line managers were supported by the human resources team. The induction period was 12 months and staff had formal reviews at months one, three, six and were signed off at month 12, there was the possibility for an extra meeting to be added at

month nine if staff needed extra support. Managers were given a checklist of all areas staff needed to have met to be signed off. This checklist meant all inductions were run equally and all staff were trained in the same things to the same level.

- Managers supported staff to develop through yearly, constructive appraisals of their work. Most staff had received an appraisal in the reporting period, 80% of doctors had, 75% of nurses or allied health professionals had and 82% of health care assistants had.
- Staff told us they found their appraisals useful as they had ongoing informal conversations throughout the year with managers about their progress. The conversations were also an opportunity to identify new learning although they were not recorded. This provided us assurances that staff were able to continually raise concerns and did not have to wait until a formal review to do so.
- Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff we spoke with told us they had ongoing discussions with their line managers about their training needs and did not feel they had to wait for formal appraisals to request further training. One health care assistant we spoke with told us they worked closely with their line manager and therefore discussions around training and development were frequent and they felt well supported. We were also told by other members of staff that they were proactively contacted about training opportunities and that they felt the hospice valued its staff and supported development.
- Managers made sure staff received any specialist training for their role. We were told about specific training given to the senior nurses who took on the role of night co-ordinator for the single point of contact line to support decision making for patients with palliative heart failure needs. This was delivered by the palliative heart failure team lead.
- Managers identified poor staff performance promptly and supported staff to improve. The hospice had a performance management framework that was used by managers to support staff who were struggled to meet their goals. This performance management was



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supported by the human resources team and was guided by the organisational values and increased the number of formal conversations that were required between staff.

- Managers recruited, trained and supported volunteers to support patients in the hospice. There was a team who managed the recruitment, training and support of volunteers in the hospice. The team supported a large number of volunteers, approximately 1,350, and kept databases to ensure they held the correct training for each role.
- The volunteer team told us the process for recruiting volunteers was varied. Some people approached the team to offer their help, some were relatives of former patients and some were recruited at a 'taster day' where people were invited to come and discuss how their skills might help support the hospice. Once a potential volunteer had been identified they were invited for an interview to ensure they were appropriate and understood the role they were applying for and following this, pending checks, were offered a volunteer role.

Multidisciplinary working

- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**
- Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed three multidisciplinary meetings, one for outpatients, one for community care and one to discuss a patient's potential admission. These were both well attended by relevant doctors, clinical nurse specialists, allied health professionals, social workers and other professionals involved in the patients care. We observed that staff not only discussed the patient's illness but also their personal goals and their holistic social and mental wellbeing. Patient cases were presented by the professional who had the closest relationship with the patient and options for ongoing care were discussed and agreed before being put to the patient and their relatives. We heard instances of safeguarding concerns being discussed along with referrals to the local authority for further investigation were made.

- The multidisciplinary team meeting was open, and each professional group was given their time to have input before decisions were made.
- In the community multidisciplinary meeting we saw staff taking the opportunity to check in with each other and offer support to care for more complex patients. At the end of the meeting a list of patients who had died in the past week was discussed to ensure their preferences were met, and learning identified if their preferences were not met.
- Staff worked across health care disciplines and with other agencies when required to care for patients.
- We saw evidence of staff working with other care agencies to support patient care. This included information sharing with GP's and district nurses, conversations with local ambulance services to discuss patient preferences and advance care plans, local care home staff and local hospitals. All these discussions were had with patient's consent to share their information. The hospice also had working relationships with all the local authorities its patients lived in and provided evidence of safeguarding referrals and deprivation of liberty safeguard applications submitted to ensure patient's care was safe.
- The hospice worked with a hospital pain management team to enable patients to have indwelling epidurals to help control pain that was otherwise uncontrollable. Epidurals are a way of delivering pain relief directly into the nervous system and works to effectively block nerves. This relationship demonstrated the close link the two organisations had, normally patients would have to be on specialist wards in hospitals to receive this level of pain relief. We were told doctors from the hospital routinely came on Wednesday afternoons, but were open to coming at other times in the week if a patient was admitted with uncontrolled pain that required this intervention. The hospice had trained senior nurses to support the doctors in the insertion of the catheters therefore lessening the burden on hospital staff having to attend the hospice.

Seven-day services

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



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- Consultants attended daily ward rounds on all wards. Consultants were involved in the ward rounds during the week and, although not on site, were available on call on weekends if more support was needed. At the ward round patients who required more consultant input were identified and then were reviewed by consultants if the care pathway required it. If required, the on-call consultant would also go out to complex community patients at short notice. We were told this was not often required as the nursing staff were able to manage most situations but was an option to escalate to.
- Staff and patients could call for support from doctors and other disciplines, 24 hours a day, seven days a week.
- The hospice offered a 'single point of contact' telephone service for patients, relative and other care agencies to call if they were concerned about a patient's condition or care needs. We were told this was used not only by patients and their relatives but also care homes and ambulance services who needed to clarify identified care needs. The service was staffed 24 hours a day seven days a week and there was capacity planned into staffing numbers to allow community visits to be made at short notice, even overnight.

Health promotion

- **Staff gave patients practical support to help them live well until they died.**
- The hospice had relevant information promoting healthy lifestyles and support on wards/units. The hospice followed a rehabilitative palliative care ethos, meaning they aimed to keep patients living the most normal life as possible for as long as possible.
- We observed that patients were encouraged, where appropriate, to keep physically active. The hospice offered daily circuits classes that patients could book into to promote their mobility. One patient told us they felt stronger and more motivated to look after themselves once they started participating in the circuits classes as they were setting goals.
- The hospice also promoted and provided services to support the mental health of patients and their

relatives. Patients could be referred to cognitive behavioural therapists, who worked for the hospice, to work through various problems such as heightened anxiety.

- There were rooms in the hospice that were dedicated to complementary therapies, for example a massage room was available. There was also a space in the pavilion in the garden for art and music therapy sessions which allowed patients to express themselves in a creative manner if they could not find the words.

Consent and Mental Capacity Act

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.**
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005. Staff were clear as to their roles under the Mental Capacity Act 2006 and were able to explain how they would protect a patient's rights under it.
- Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff gaining consent for procedures and recording this in their records. Staff explained procedures to patients and their relatives and made sure they had the information they needed to make an informed decision about a treatment. Staff included families in discussions about courses of treatment but ultimately the decision to proceed with treatment was made by the patient.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were clear about the processes to assess a patient's capacity and explained how they would vary their approach if a patient had fluctuating capacity. Fluctuating capacity means that a patient may have the capacity to make decisions at certain times and



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not others. Staff explained with this group of patients they would time conversations when they knew the patient would have the capacity to make decisions for themselves and would work on developing advanced care plans with patients, so they could make choices for the future of their treatment.

- The hospice worked with patients as much as possible to develop advanced care plans to ensure their wishes were documented for future care needs. An advanced care plan is a plan patients make that sets out their decisions for future treatment, should they lack the capacity to do so. Advanced care plans are used when patients no longer have the capacity to make decisions for themselves and enable health care professionals to honour patients' wishes. The hospice supported patients and their relatives to create advanced care plans as early as possible in their care, these were then logged in both the hospice patient records and in the patient's 'co-ordinate my care' record.
- We saw that mental capacity assessments were recorded in patient's electronic records. The assessment we looked at was completed in full and updated as required. Each decision that was made for the patient who was deemed not to have capacity was logged in the record.
- When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. If patients did not have advanced care plans in place or relatives with power of attorney over health care, staff set up multidisciplinary best interest meetings to make decisions. The hospice had arranged three well attended conferences about best interest meetings to teach other care providers how to manage them. We were not able to observe any best interest meetings while on site, however we saw notes taken during meetings and found them to be well attended and open discussions were recorded.
- Staff made sure patients consented to treatment based on all the information available.
- Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The hospice was in the process of redeveloping its training package teaching staff about

the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were still able to access the current training information, but the hospice felt it needed an update. Staff we spoke with were able to explain when they would consider asking for a Deprivation of Liberty Safeguards assessment and the processes that were needed to ensure this happened in a timely manner.

- Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. The safeguarding lead monitored Deprivation of Liberty safeguarding applications and was part of the team involved in signing off emergency applications to allow safeguards to be put in place for up to seven days while waiting for the local authority to approve longer term use.
- Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were able to locate both the Mental Capacity Act and Deprivation of Liberty Safeguards policy on the intranet. We saw that these policies were comprehensive, followed guidance and were in date.
- Managers monitored how well the hospice followed the Mental Capacity Act and made changes to practice when necessary. The hospice had a safeguarding, Mental Capacity Act and Deprivation of Liberty committee where the number of referrals were noted and case studies were scrutinised and discussed and changes to policy following changes to guidance could be agreed. This was where the changes to the training programmed had been instigated. The lead was able to identify the common themes and problems faced by staff and was tailoring training to cover these.
- Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. The hospice had intake from multiple different local authorities and staff were able to explain how they would submit documentation to all of them.

Are hospice services for adults caring?

Good



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



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Compassionate care

- **Staff truly cared for patients with compassion. Feedback from all patients and those close to them confirmed that staff treated them well and with kindness.**

- Staff within the service took the time to understand patients as individuals and created care that was personalised to their needs. Individual needs and preferences were always reflected in the way care was provided. For example, we observed a patient with a cognitive impairment had a list of preferred things to eat and activities they enjoyed. Staff told us this information was collected on admission for all patients with cognitive impairments such as dementia from family and carers to ease the transition into the hospice environment. We observed staff always prioritising patient goals in the care delivered.
- Patient's feedback confirmed that staff treated them well and with kindness. Staff highly valued the relationships between patient, relative and staff. The leadership team encouraged and supported the building of these relationships. We observed patients being offered to attend the hospice's brass band in the anniversary centre and staff sitting and interacting with patients while this was going on. In the community setting, staff set the length of time they spent with patients, this enabled them to extend visits when needs became more complex or the patient needed longer to make decisions about their care and treatment. Staff told us there was no pressure from managers to spend a certain amount of time with each patient and this gave them the flexibility to care for patients in a compassionate way as they had time to get to the heart of what patients wanted.
- Staff were consistently observed displaying kindness and compassion towards patients and their relatives which helped to reduce their anxiety. We observed that patients, family members, friends and fellow staff were always treated with dignity and respect. Consideration of patient's privacy and dignity was firmly embedded in the way staff approached daily tasks. For example, we observed staff ensuring patient dignity was protected during personal care by closing doors and curtains of bedrooms and bays.
- There were good patient feedback channels and staff acted on any concerns patients highlighted throughout their stay. The results from this feedback were consistently highly positive over both 2018 and 2019. In the 'Voices' survey patients and relatives were asked 'Overall, how satisfied were you with the care you received from St Christopher's?'. The hospice scored 9.36 out of 10 in 2018 and 9.38 out of 10 in 2019. Patients repeatedly told us they valued the relationships they built with staff and the 'limitless lengths' they felt staff would be willing to go when providing care and support.
- Staff told us the hospice conducted weddings in the gardens or anniversary centre, allowing patients to celebrate special occasions with loved ones and that they did all they could to ensure these were special occasions. The hospice had a chaplaincy team to conduct ceremonies but, if patients wanted, they contacted other religious leaders to conduct ceremonies. The hospice conducted both heterosexual and same sex wedding and civil ceremonies.
- Staff were passionate about creating positive memories for patients and families during their time as an inpatient. For example, during our inspection we observed a local school brass band visited the hospice to provide music for patients. Families were supported to eat together by staff, depending on the patient's condition they could eat at a table in the anniversary centre away from the ward.
- Dignity of deceased patients was maintained through the hospice's processes of last offices and transferring the deceased person to the mortuary to await collection by local funeral services. Last offices is the process to prepare the deceased for a funeral home and involves washing the person.
- Patients could reach call bells and staff responded quickly when called. We observed all call bells to be within the reach of patients and to be attended to quickly. No patients we spoke with said they had been left waiting for help when a call bell had been used.
- Staff told us about a patient who travelled to the UK and became acutely unwell. They were cared for in the hospice and a member of staff was preparing to fly



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home with the patient, as an escort, as their preferred place of death was home. Staff worked collaboratively to facilitate the repatriation by approaching the embassy and airlines.

Emotional support

- **Staff understood the importance of providing emotional support to patients and those close to them and were willing to go ‘the extra mile’ in order to meet their needs.**

- We observed that staff were attentive to and prioritised the holistic needs of patients at the hospice. The hospice had a chaplaincy team, social workers, cognitive behavioural therapists and a complementary therapy team who worked with clinical staff to ensure patient’s and relative’s holistic needs were catered for. Members from these teams attended ward rounds and multidisciplinary meetings and were regularly consulted to ensure staff had a full understanding of all the needs of the families cared for.
- The emotional and social needs of patients were as important as their physical needs with a wellbeing team made up of four health care assistants (HCA) dedicated to this purpose. Patients had a monthly review with a member of the wellbeing team to evaluate the support they were currently receiving and any additional support they might benefit from.
- The day therapy service included the option to take part in wellbeing crafts, music therapy and art therapy. This included conducting life story work with patients which allowed them to create memory boxes, photobooks, video diaries and audio recordings of their lives. For example, one patient told us they had been assisted by the music therapist to create a soundtrack of songs for their family to remember them by.
- Bereavement sessions were offered on a one to one basis or as a group depending on the preferences of relatives. A specialised bereavement service called ‘Candle’ was run for bereaved children. The group provided one to one and group counselling to offer practical support to bereaved children and meet their emotional needs. The service also offered training or advice to support to local schools to support them in understanding the needs of bereaved children.

- The bereavement team ran events to support and remember loved ones such as a quarterly remembrance event for relatives who had lost loved ones. The bereavement team also set up and ran bereavement help points in seven locations throughout South East London that provided the local community an opportunity to access bereavement support without visiting the hospice.
- Staff communicated sensitively and thoroughly with patients and their relatives. Patients told us they were able to ask any questions and were given answers they understood and emotional support when upset. Patients and relatives commended staff provision of thoughtful and empathetic support. Staff offered assurance and reassurance to relieve anxiety and enable patients to settle into the hospice and benefit from the support provided.
- Staff emphasised the holistic needs of individuals. People’s personal, cultural, social and religious needs were always considered with innovative ways to meet them being found. Patient needs were reviewed regularly and dynamically to relieve as many worries as possible and ensure needs continued to be met effectively. Staff had undergone training with the complementary therapy team in the ‘Namaste Care’ programme to help to provide holistic care to patients with advanced dementia.
- The hospice provided ‘Compassionate Neighbours’ support across the five boroughs the hospice served. Patient referrals could be made through any member of staff or relatives and friends through a form on the public website. ‘Compassionate Neighbours’ is a social movement where local trained volunteers visit patients in their home to alleviate social isolation. The hospice also ran a ‘Coach4Care’ programme which paired a carer who was bereaved with a carer caring for somebody at the end of their life. This allowed carers to use their experience in a meaningful way and to be able to give real examples of how they helped their loved ones. New carers were able to speak with somebody to had real experience of what they were going through and who could truly empathise with them.
- The hospice also ensured they supported the emotional wellbeing of their staff. They ran ‘Schwartz rounds’. Schwartz rounds are used in healthcare to



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provide staff, and in this case volunteers, an opportunity to discuss any emotional or social issues that may arise from caring for people at the end of their life. They also encouraged huddles to allow staff to discuss complex or upsetting cases daily, particularly in the community team who were often working alone.

Understanding and involvement of patients and those close to them

- **Staff always 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 hospice had a clear patient-centred culture. Staff were impassioned to provide kind care that promoted dignity and independence wherever possible. This was supported by the hospice's rehabilitative palliative care ethos aimed at keeping patient's living as well as possible for as long as possible, as defined by the patient.
- Staff routinely included patients and relatives in planning and decision making about their care and treatment. Patients took an active role in their care and defined personal goals they wanted to achieve. We observed that patient goals were always discussed at ward rounds and at multidisciplinary meetings demonstrating they were used as the foundations for building care plans for patients.
- Patients carers, advocates and representatives including family and friends, were identified, welcomed, and treated as key partners in the delivery of their care. Staff took their concerns on board when discussing patient care, but ultimately delivering patient wishes was their priority.
- We saw evidence in patient care records that staff routinely involved patients and those close to them in the decisions about the patients' care and treatment and in developing their care plans. Patients and relatives told us that staff answered questions about their care openly and with clear information. We observed community nursing staff involving and engaging patients and their relatives in discussions about care planning.

- Staff supported patients in making advanced decisions about their care. Patients were given information about their options and support in making choices about topics such as the preferred place of care. We observed staff talking to patients and their families about death and the dying process. They were clear yet compassionate and caring towards patients or relatives who became upset and enabled those involved to ask as many questions as they wanted to.
- The hospice provided a 'Coach4Care' programme that enabled current family carers to receive one to one coaching from trained ex-family carers. We were told this was beneficial for the current carers as they received advice from people who had experienced their reality. The coaches also reported they found being able to use their experience fulfilling and gave meaning to their experience.
- Staff were able to access advanced communication courses to ensure they communicated effectively and compassionately with patients and relatives.

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

Outstanding



Our rating of responsive improved. We rated it as **outstanding**.

Service delivery to meet the needs of local people

- **The hospice planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**
- Managers planned and organised services so they met the changing needs of the local population. The hospice kept a database tracking the ethnicity and other protected characteristics of patients they cared for and made safeguarding referrals for. This was interrogated by the trustees to ensure the hospice was caring for people that was representative of the demographic it served.



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- Managers explained how they tailored services to specific populations depending on the demographics of those areas. For example, they knew that one of their local clinical commissioning groups (CCG) had the highest average age population of any London CCG. CCGs cover a certain population and assign funding to the health care services which serve those populations. This knowledge led to the hospice, with support from the CCG, setting up a frailty service as the hospice had noted an increase in non-specific referrals for frail, elderly patients. The frailty service assessed and co-ordinated care for frail patients in a proactive way as opposed to reacting to problems as they occurred. This involved the hospice making 'parallel plans' with patients and relatives. Parallel plans are plans which run in parallel and diverge as outcomes change. By making parallel plans the hospice aimed to plan for as many eventualities as possible, with the patient's involvement in their care. The frailty service co-ordinated the care of patients with other care providers and gave patients a single point of contact should their condition change or develop. 70% of patients cared for under the frailty service were supported to die at home, this is in contrast to 16.7% of comparable patients across the South East England Region.
- Another service that had been developed to meet the specific needs of a patient group was the heart failure service. This service was developed, in collaboration with a local acute hospital, to support patients with heart failure access services smoothly and therefore improve outcomes. The pilot was deemed successful by the clinical commissioning group (CCG), with a 36% reduction in admissions, a 51% reduction in hospital bed days and reduction in the proportion of patients attending A and E for cardiac reasons. As a result the CCG are now funding a heart failure nurse to support this project to be continued in the long term.
- Another area where the hospice was responding to the specific needs of its population was in Croydon, which had a large homeless population. The hospice was working with hostels in the local area to train staff to identify the signs that a homeless person might need end of life care and then to refer them to the hospice. This was aimed at reaching a traditionally difficult to reach group to ensure they receive care at the end of their lives.
- Managers had also identified certain care homes in the area that needed support in caring for dying patients. They had produced a data base of care homes in their catchment area and detailed how frequently they had to manage end of life care and how effectively advance care plans and/or end of life care had been managed historically. This meant they were able to target resources and provide more community visits to care homes which required more support. This information was available to the telephone and visiting service who took the calls from the care homes and formed part of their decision-making process when allocating resources.
- Managers explained to us about the hospice's evolving model of care, which was developed to enable them to support as many people as possible. Traditionally the hospice model of care was to care for people at the end of their life and to facilitate a comfortable death. St Christopher's was moving to a more community-based care model and prioritising in-patient referrals to help patients gain control of symptoms. Once symptoms were controlled patients were discharged either home, to a loved one or to a care home if needed and care was handed back to the community team. Alongside this new model of care the hospice supported members of the community to care for people more effectively and used programmes such as 'coach4care' and 'compassionate neighbours'. This was part of the hospice's long-term plan to ensure everybody received high quality end of life care but, with the recognition that the average age of the population was increasing as were people's care needs. By increasing community involvement in care more patients could be cared for then just those able to access the inpatient unit.
- Another part of the new care model was 'rehabilitative palliative care'. This model of care understands that palliative patients can live a long time and want to maintain a high quality of life. The model worked with patients to set goals that were important to them and then develop plans that helped them achieve their goals.
- Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Most of the in-patient accommodation was single rooms to allow patients



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and relatives privacy. On the wards which did have bays these were kept single sex, and this was adhered to all the time. We asked staff what would happen if there was a bed on a female bay and a male patient needed admitting and were told they would look at stepping down a female patient from a side room, with their consent, to free a space. If this were not possible the bed would remain unfilled and the patient would be admitted when a suitable bed could be found. We were told this had not happened in the past 12 months and the hospice had enough flexibility with beds, with patients being discharged or passing away that they had always managed to adhere to single sex bays.

- Facilities and premises were appropriate for the services being delivered. Facilities and premises were designed with patient's needs in mind. Wards provided enough space for patients to independently mobilise if they wanted to and had seating for relatives, with space for them to sleep if they felt they needed to.
- Managers told us previously they had noted lower engagement from the LGBT population they served and sought to ensure they felt included in the hospice services. They noted, in particular, the community had not made use of the wedding and civil partnerships services they offered. In order to address this, they amended their leaflets to ensure same sex couple images were included on the front cover. We were told this had greatly increased the engagement from the LGBT community throughout the hospice.
- Wards also all had side rooms for relatives to use if they needed privacy, or to facilitate private discussions with families. The anniversary centre had a range of seating for patients to be able to sit in a chair that was comfortable for them.

Meeting people's individual needs

- **The hospice was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**
- Wards were designed to meet the needs of patients living with dementia. The ward environment was calm

and quiet and as patients were predominantly in single rooms they were able to bring in items from home to help reduce anxiety. There was good natural light in all bed areas and social spaces, the flooring was matte and not overly patterned, there were places for patients to sit and rest along corridors and in stairwells and the signage was clear and in contrasting colours with an easy to read font.

- Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The staff were trained to care for patients with dementia and there were 'dementia champions' throughout the hospice who were able to support with any more complex care needs. Staff not only supported patients with dementia but also their relatives. While on inspection we were told they were creating a memory box for one patient's spouse to help preserve physical memories and for another patient's spouse, with sight loss, they were creating a music CD and memory box which had braille writing on, so they were able to identify it.
- Managers made sure staff, and patients, relatives and carers could get help from interpreters or signers when needed. The hospice had access to interpreters, when required, and they were routinely used for clinical discussions or mental capacity assessments to ensure the information was translated accurately. Interpreters were available on the phone or in person.
- Patients were given a choice of food and drink to meet their cultural and religious preferences. The hospice offered a wide range of food for patients and allowed relatives to bring favourite food from home, if preferred. Food was prepared carefully and in line with specific religious requirements. Patients were permitted to drink alcohol with dinner if they wanted to.
- The hospice actively sought to achieve goals set by patients and these were routinely discussed along with the medical, social and psychological needs. Examples of goals we heard discussed included getting out into the gardens every day or reducing breathlessness to enable the patient to move around more comfortably.
- The hospice had no restrictions on visiting hours, however staff asked relatives to let the nurses know if



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they wanted to stay overnight so beds could be set up if required. They allowed pets to visit, as this was often important to patients and helped to keep them calm. The hospice had a resident cat, Colin, who patients were welcome to pet if their own pets could not be bought in.

- The hospice actively sought out patient's views on their services when they were making changes. For example, they were planning to refurbish the wards and, in preparation to make plans, had asked for patients and relatives views on what could be done to make their experiences easier.
- The hospice also had a gym on site. We were told the gym was primarily used by outpatients to promote a more active lifestyle in a safe environment but was also used for inpatients undergoing physiotherapy. The gym had equipment that could be modified for patient requirements. For example, an upper body weight machine that could be used standing or sitting in a wheelchair if a patient's lower body strength was compromised. Similarly, there were recumbent bikes which allowed patients to use either upper body or lower body to drive them.
- The patient rooms and all bays had reclining chairs for relatives to sleep in and enough space for a spare bed to be set up for a family member to stay overnight.
- The hospice had a multi faith space called the 'Pilgrim room' for anybody to use to sit and reflect or pray if they wanted. In the Pilgrim room there were religious texts and books of a more spiritual nature. There was space to safely light a candle for a loved one and a rosary or prayer mat if patients or relatives needed. The space also held a book for relatives to write messages for loved ones, all the old books were also available in the room. We were told many relatives chose to come back each year and write a new message and reflect on previous messages they had left; therefore, the hospice left the old books for reference.

Access and flow

- **People could access the hospice when they needed it and received the right care promptly and the hospice had provisions in place to risk**

assess referrals to allow emergency admissions to services to be prioritised. Any wait lists were reviewed by managers or senior care staff to allow urgent referrals to be prioritised.

- Managers monitored waiting times and made sure patients could access services when needed. The hospice had a 'single point of contact' where all referrals and patient queries went through. This service was monitored by the managers and was open 24 hours a day seven days a week. The service took calls and then risk assessed for how quickly a referral to either the inpatient unit, community team or outpatient service was needed. This original risk assessment was supposed to be completed within 24 hours of taking the phone call. The most recent audit completed in November 2019 and reviewed 142 cases discussed over a seven-day period showed the service was meeting this target 88% of the time. 14 of the 17 referrals which missed the 24-hour time frame were responded to within 26 hours, however the computer system did not display time stamps to the contact team, this was due to change with an upgrade to the system plan for January 2020. The remaining three referrals were responded to late due to a lack of staffing over the weekend and there was an extra administrative position created to cover this, they were due to start in January 2020. A re-audit was planned for February 2020.
- Community teams explained their processes for reviewing and prioritising caseloads depending on the needs of the patients. For example, a patient with relatively simple needs and who was relatively well would be seen once every few weeks by a healthcare assistant and a patient with more complex and acute needs would be seen more frequently by a clinical nurse specialist. Patient needs were assessed regularly and the category they fell into was fluid. The assessments and categories were written into protocols meaning staff were confident they delivered appropriate care.
- The hospice told us the average number of days a patient waited for admission to the inpatient unit was two, the minimum number of days was zero and the maximum nine. It was explained that the longest waits, of nine days, were where patients had been referred from local hospitals and were not fit for



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transfer, therefore the patient had to wait until they were well enough to be transferred. The wait list for inpatient admissions was reviewed twice a day by a consultant nurse or a doctor which the single point of contact team.

- The hospice told us the wait times for access to community teams was between zero and 11 days, including weekends. If patients were assessed as having urgent care needs they were seen on the same day as referral. The waiting times for an outpatient appointment were between one and nine days, with an average of five days.
- St Christopher's had also begun discharging patients from community caseloads when symptoms were manageable for patients and relatives. However, the discharge allowed self-referral back into the system should things change by calling the 'single point of contact' number. This enabled community staff to maintain a manageable caseload but also gave patients and relatives the reassurance they could access help and support as and when they needed it in the future. This was part of the hospice's new care model and enabled them to care for a higher number of patients as they were not routinely seeing patients whose conditions were stable and did not require intervention.
- The outpatient clinics were open long hours to enable patients or relatives to book appointments at times that were suitable for them. Bereavement support groups ran over evenings and weekends so relatives or loved ones could access these outside of work hours.
- Managers and staff worked to make sure that they started discharge planning as early as possible. Potential discharge plans were discussed with patients and relatives early to ensure their needs and preferences were considered. When patients were admitted to the hospice, to aid control of symptoms, we observed they were told that this was the case and they would be discharged back to the community or a care home once symptoms had been controlled.
- Staff planned patients' discharge carefully. We saw evidence of complex discharge planning and staff were clear about their duties to ensure thorough discharge plans were in place before patients went home. The hospice had robust links with the local

authorities it served, and staff knew the social care system and how to guide patients and relatives to get the support they required. When patients or relatives were unable to access the support, the hospice did this on their behalf.

- When patients had stipulated a preferred place of death as home in their advanced care plans the hospice was able to fast track discharge to achieve this goal.
- The complementary therapy team offered a range of therapies supporting patients and their relatives including massage and acupuncture. The team included a community-based member who could travel to patients' homes in circumstances where the patient was unable to travel to the hospice.

Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received. The hospice treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The hospice included patients in the investigation of their complaint.**
- Patients, relatives and carers knew how to complain or raise concerns and the hospice clearly displayed information about how to raise a concern in patient areas. Patients and relatives we spoke with were aware of how to raise concerns or complaints if they had any. There was clear signage throughout the hospice environment detailing how to complain and patients were given a "Welcome to the inpatient unit at St Christopher's" leaflet when they were admitted to the ward which detailed the complaints process.
- Hospice volunteers were also trained to speak with patients on the wards to ask for real time feedback and to collate this in the form of a survey. This meant problems could be addressed in real time and stopped issues escalating, rather than patients having a poor experience and complaining after discharge.
- Staff understood the policy on complaints and knew how to handle them. Staff were clear in their role for how to manage complaints. We saw a clear complaints policy with defined dates for responses to be sent to patients or relatives by. This policy had recently been updated to ensure it was thorough.



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When a formal complaint was received the hospice acknowledged this by letter and offered the complainant a meeting to discuss the complaint. This allowed the hospice to understand the complaint thoroughly and ensure it was investigating appropriately. All complaints would then be investigated and discussed by a multidisciplinary team at a learning panel. There the complaint was looked at for any potential learning. This learning was then disseminated to staff and sent to the original complainant, so they were aware of the changes they had enabled for future patients. We were told by the hospice they were proud of their complaints investigations and had a previous complainant working as a volunteer as they were so impressed by the hospice's reaction to their complaint.

- Managers investigated complaints and identified themes. We were told one of the themes that was identified was that small concerns that were not identified while a patient was on the ward led to larger complaints being fed back on the bereavement questionnaire. This led to the hospice training volunteers to gather feedback from patients and relatives while they were on the ward, so any problems could be actioned in real time. The hospice explained the rationale for using volunteers which was that patients felt more comfortable to speak freely with somebody who was not delivering their care.
- Managers shared feedback from complaints with staff and learning was used to improve the hospice and staff could give examples of how they used patient feedback to improve daily practice. The recommendations from the learning panels was used to inform changes to policies and procedures and staff were able to speak about changes that had happened as a response to complaints.
- Managers looked at the content of compliments as well to understand what the hospice was doing well and to see if this could be built on in any other areas.
- During the reporting period, of September 2018 to August 2019, the hospice received 28 complaints of which nine were upheld and 27 were responded to within the target date. In the same reporting period the hospice received 477 compliments.

Are hospice services for adults well-led?

Outstanding



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

Leadership

- **Leaders had the skills and abilities to run the hospice. They understood and managed the priorities and issues the hospice faced. They were visible and approachable in the hospice for patients and staff. They supported staff to develop their skills and take on more senior roles.**
- The management at the hospice were committed to their roles and were passionate about delivering great care and pushing forwards to ensure the hospice remained a sustainable organisation. They were visible to staff and staff told us they knew who they were and found them to be approachable. The hospice had two chief executives who worked collaboratively, underneath them there was the executive team who managed the wider leadership team. The leadership was clear and had defined structures and channels of communication. The executive team had defined roles such as medical director and director of quality and innovation and these roles were defined and had clear responsibility and accountability.
- Staff told us they found managers approachable and felt supported by them. There were initiatives at the hospice, such as the audit teaching programme that were designed to integrate hospice leaders with the staff and to enable open and honest conversations about the challenges that faced staff daily.
- We noted that as we were walking around the hospice with managers that they knew all the staff and staff knew who they were. There appeared to be no barriers to communication and staff approached managers to ask questions while we were there. This was also demonstrated in the 2019 staff survey with a 20% improvement in staff confidence from the 2018 survey.
- The registered manager was dedicated to the hospice and felt the board and trustees were equally



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passionate about delivering the best care they were able to. They were equally committed to the education programme St Christopher's offered. This programme was a mixture of delivering speeches at conferences, classroom learning for clinical staff and community members and electronic learning delivered to staff from other organisations. All education programmes were aimed at achieving the new care model of enabling effective care for dying patients in the community as much as possible and preserving in-patient care for those with acute symptom burden.

- The director of people and organisational development explained to us that the hospice had sent 28 managers on management development programmes. This enabled managers in the hospice to feel more confident in their roles and supported staff to progress to more senior roles.

Vision and strategy

- **The hospice had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services, increasing the reach of the hospice and improving the quality of the service.**
- The hospice had a clear vision which was “a world in which all dying people and those close to them have access to the care and support they need, when and where ever they need it”. They hospice hoped to facilitate this vision by promoting and providing “skilled and compassionate palliative care of the highest quality”.
- The hospice also had well defined values, which were embedded in protocols and therefore in day to day working at the hospice. These values were to be “empowering and compassionate”, “expert”, “of and for the community”, “stronger through partnerships, “one team working together” and to be “pioneering and bold”. We saw these were translated into practice and staff were able to tell us them. These values were also embedded in the appraisal system.

- The hospice had organisational objectives and behaviours and ensured they were aligned to the corporate values. This was looked at by the leadership team and a document had been produced to assess how well they were achieving their values in each area.
- The hospice had a five-year plan that was complimented by yearly objectives set by the senior leadership team and approved by trustees and the board members.
- Part of the hospice's overall strategy was to change its model of care to increase the sustainability of its impact on patients, this was an ongoing process. The hospice was acutely aware of the demographic trend of an ageing population with a higher disease burden and recognised that their previous model of care of looking after people on the inpatient unit until they passed away was not sustainable. This had led to a shift in the care model and the hospice was caring for those with high symptom burden in the inpatient unit while also caring for patients in the community for as long as possible under the rehabilitative palliative care format. This enabled patients to live normal lives, out of care environments, for as long as possible and as well as possible.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The hospice promoted equality and diversity in daily work and provided opportunities for career development. The hospice had an open culture where patients, their families and staff could raise concerns without fear.**
- Teams worked collaboratively with each other with the shared focus of providing high quality care for patients. We saw evidence of community teams and the inpatient unit communicating seamlessly to ensure patients were not lost in the system and therefore miss out on any care they required. This level of teamwork extended beyond the immediate hospice staff and into the hospitals and other care agencies they had links with. The hospice had forged meaningful working relationships with many other agencies such as local hospitals, hostels and CCGs and this allowed integrated care to be delivered.



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- Community staff told us that although they physically worked outside the hub of the organisation they felt a part of it and were able to voice their opinions and felt valued.
- The hospice valued staff safety and promoted safe working practices. There was an in date lone working policy and staff from the community had personal safety devices should they require assistance when in a patient's home. We noted that at the multidisciplinary meeting staff safety was discussed and risks were mitigated with the decision to send two members of staff to some patients where support may be needed.
- All staff we spoke with told us they felt the goal of achieving good patient care was at the crux of everything the hospice was doing. They told us they were not pressured to discharge patients from services and community staff were able to set their own day plans to enable them to spend as long as was necessary with patients. This meant visits were not rushed and staff felt they were able to provide the care they needed to. This flexibility enabled and empowered staff to deliver patient centric and holistic care.
- The hospice had an in-date whistle blowing policy and staff told us they were aware of it. In addition to this the hospice had a trained freedom to speak up guardian staff could approach. However, staff we spoke with said they would not feel the need to use it as they felt able to raise issues openly, without fear of future repercussions.
- Staff we spoke with told us they were proud to tell people they work for the hospice and that they felt able to deliver truly personalised care for their patients. We were told by staff they were hesitant when the new model of care was being bought in because they were afraid they would deliver less patient centric care. However, once the model was in place and the audit data was published they were able to see this was not the case. We were told by one member of staff who was contracted to the hospice that they felt the care they observed was “effortlessly natural” and “truly holistic”.
- **Leaders operated effective governance processes, throughout the hospice and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the hospice.**
- There was an effective governance structure. All meetings within the governance framework were well attended, and this had been actively worked on in the previous year. Staff at all levels were clear about what their roles and responsibilities were. There were clear lines of accountability throughout the hospice structure and all staff were clear about who they were accountable to and who to escalate problems to.
- The hospice enabled and promoted open discussions at all levels about care delivered and potential improvements to the care being offered.
- The hospice had peer group meetings such as the consultant forum, the ward managers meeting and the prescriber's meetings to enable open discussions about any good practice to be highlighted or concerns to be shared. These meetings were recorded, and minutes were shared with members for sign off. All meeting minutes we saw were clear and had defined outcomes and actions which were owned by members of staff to complete.
- The hospice held quality and governance meetings four times a year and these were chaired by the director of quality and innovation. This role of 'the governance and innovation' lead was new and was created as the two were intrinsically linked. It was appreciated by the hospice that all innovation needed governance processes to maintain safety, but that governance should not suppress innovative ideas, by creating a new role the two could remain in balance.
- The hospice had a clear governance process to continually improve services. Staff of all levels were clear in their roles and responsibilities in relation to governance and we found governance arrangements to be suitably vigorous.
- The hospice held board meetings which were attended by the executive team and trustees. Directors submitted reports containing performance, quality or incidents for

Governance



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each other and the trustees to interrogate. We were told by the members of the executive team that the trustees would challenge the content of the reports where necessary.

Managing risks, issues and performance

- **Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected event.**

- The hospice had continuity plans in place to cover various issues and had mitigated risks such as power loss by having routinely serviced backup generators. In early 2019 we received notification that some of the fire precautions at the hospice were not safe. Since then we have been provided a thorough action plan and updates to how this is being managed and are assured the hospice had managed this risk well.
- The hospice held a risk register and all members of the senior leadership team were able to describe the main risks. The register contained mitigating actions, a responsible member of staff in charge of the action and the review date. We found the items on the risk register, such as ongoing charitable funding, to be appropriate.
- There were clear lines of accountability and responsibility in the hospice. The hospice had nominated leads for areas such as infection control, safeguarding and finance. These leads reported on their areas at meetings and answered to the chief executives and trustees for the quality of the information they presented.
- The hospice reviewed the content of complaints compliments and concerns to drive improvements and to uncover risks they may otherwise have not been aware of. The full complaints review process is discussed in responsive.
- The hospice had developed a risk appetite statement. This statement was aimed at guiding staff and volunteers about the hospice's definition of appropriate risk taking.

Managing information

- **The hospice collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**
- We found the information systems to be secure and appropriate for use. The hospice had identified improvements that would be driven by updates to the patient record system in due in January 2020. The systems enabled data to be extracted and analysed accurately as all entries were automatically timed and date stamped. Most staff we spoke with, apart from new staff who were still undergoing training, were confident to use the systems.
- The hospice had mechanisms in place to manage safety notifications from outside agencies to ensure patients and staff were kept safe. The hospice also submitted statutory notifications to us, as appropriate, and was compliant with requests for further information when required. We were also told about the mechanisms of reporting to other agencies, such as the yellow card reporting to the Medicines and Healthcare products Regulatory Agency.
- Information governance training was part of the mandatory training for all new staff. Staff members we spoke with were aware of their responsibilities to comply with good information governance and management. We observed that computers were locked when staff were not using them.
- IT systems were all password protected and users had to log into each system individually once a computer had been accessed. This enabled accurate records to be maintained as staff had to proactively log into systems to update notes.

Engagement

- **Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**
- The hospice asked its staff to complete an annual staff survey and acted upon the results of these. We were



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told the 2018 survey had raised some concerns with managers and improvements had been made. The 2019 staff survey demonstrated improved satisfaction of staff.

- The hospice had multiple mechanisms for patients and relatives to provide feedback on services. All this feedback was scrutinised, and themes and trends were identified to improve the future service the hospice provided.
 - Along with these ongoing programmes the hospice also sought targeted feedback when projects were launched. For example, when the hospice was planning to refurbish the ward environment it asked staff and patients what could be done to improve things. As the end users of the services the hospice recognised they could provide insight into details that may otherwise be missed. This feedback was used to fine tune designs and ensure the environment was as appropriate for as many patients as possible.
 - The hospice worked collaboratively with the local authorities and Clinical Commissioning Groups (CCGs) to deliver services which were needed in the areas they covered. An example of this is the frailty service that was set up in conjunction with the CCG. The hospice and CCG work collaboratively to provide this service to the population and the service was driven by demographic needs as these patients would not have previously met hospice referral criteria.
 - The hospice also worked with services that were not traditionally deemed health care providers. These services included hostels and enabled the hospice to provide care to the homeless population it served. From this engagement the hospice had spoken with members of the homeless population and had a better understanding of their needs. Because of this they had made a funding application for a new programme called “ripples” aimed at ensuring everybody could leave a legacy, as this was often highlighted as a concern by homeless patients.
 - The hospice ran a staff forum, that was chaired by a member of staff. They also ran a forum for volunteers to give them a formal way of speaking with the organisation and voicing their opinions.
- **All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**
 - The hospice was committed to learning from when things had gone wrong and when things had gone well and regularly audited itself to benchmark progress.
 - The hospice had a ‘people and workforce development strategy’ which offered training and development opportunities including a new ‘Never too Busy to Learn’ programme which focussed on using everyday examples to learn as part of their role. Many senior members of staff we spoke with had worked at the hospice for years and had been upskilled to take on more responsibility and new roles. The hospice understood the benefit of cultivating talent and providing new opportunities to staff to retain them.
 - The hospice had introduced Schwartz rounds for staff to attend. Schwartz rounds are used in healthcare to provide staff, and in this case volunteers, an opportunity to discuss any emotional or social issues that may arise from caring for people at the end of their life.
 - The hospice was in the end processes of building a new educational hub. This was a building separate to the hospice which was to become the hub from which all training was delivered. They utilised technology in delivering training and understood not all care services were able to release staff from duties for whole days to attend training. Therefore, they offered dial in sessions which were held on a digital platform, this increased the number of people they would reach with training. The hospice was targeting training and education programmes at care homes and local communities. This was part of the long-term strategy to keep as much care in the community as high quality as possible.
 - The hospice was actively engaged in research and delivered speeches and posters at conferences worldwide. At the time of inspection, they were contributing data to a new research project which was aimed at providing more accurate methods for hospices to benchmark effectiveness against each other. The aim being to compare their services with other services nationally to allow them to identify areas for improvement in the future.

Learning, continuous improvement and innovation



Hospice services for adults

- The director of quality and innovation was actively involved in a 'community of imagination project'. This was a collaborative project that promoted out of the box problem solving to enable creative solutions to problems in end of life care.

Outstanding practice and areas for improvement

Outstanding practice

- The hospice had specialist services set up in partnership with a local NHS trust to enable patients to have indwelling epidurals to deliver constant pain relief when traditional pain relief was not working. This was not normally offered outside of specialist hospital units.
- The hospice had a dedicated frailty service targeting the older community. This had been set up in collaboration with the local CCG and provided patients with non-specific symptoms expert care and support at the end of their life.
- The hospice had taken steps to reach traditionally harder to reach communities such as the homeless population and were speaking with them to understand what was important to them and was in the process of tailoring a new programme to meet these needs.
- The hospice was developing a new model of care to allow it to provide high-quality care to as many people as possible in a sustainable manner. They were planning and anticipating an increased demand for hospice care, because of this they were adjusting their model of care to allow for greater flexibility in the future.
- The bereavement team ran bereavement help points in seven locations throughout South East London that provided the local community an opportunity to access bereavement support without visiting the hospice.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all staff are aware and compliant with the 'care after death' policy, with reference to the infection control procedures to keep other staff members and undertakers safe.
- The provider should continue to work to fully understand the causes for the higher than average prevalence of pressure ulcers.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.