

# Compton Hospice Limited

# Wolverhampton

# Lymphoedema Service

## Inspection report

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## Ratings

Overall rating for this service	Good ●
Is the service safe?	Requires Improvement ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

# Summary of findings

## Overall summary

This inspection took place on 5 April 2016 and was unannounced.

Wolverhampton Lymphoedema Service is a specialist service offering treatment and advice for people who experience Lymphoedema, (swellings and inflammations usually of the arms and legs). This may be due to damage to the Lymphatics through accident, infection or cancer and its treatment. The Lymphoedema service covers the Wolverhampton and Dudley areas by appointment between Monday to Friday. The services offered by Wolverhampton Lymphoedema Service supplement and complement existing service provision at the main Compton Hospice. Staff can refer people to internal services such as bereavement support, complementary therapies, physiotherapy and the day centre. At the time of the inspection there were five people attending appointments at the clinic.

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

There were shortfalls with the arrangements for managing people's dressings and creams. Although immediate action was taken to rectify this the provider's safety monitoring should have picked this up to ensure the arrangements in place were safe, sustained and effective.

People told us that they felt safe when attending for their appointments and had no concerns about the way that staff supported them. Staff had been trained to recognise harm or abuse and knew how to report this to promote people's safety.

Staff were aware of and followed the risk assessments developed by health care professionals with primary responsibility for the provision of people's care. Treatment plans identified risks to people's well-being and we saw staff monitored and communicated any concerns with relevant healthcare professionals.

People's safety was promoted and all accidents and incidents were regularly reviewed by the management team and action taken to improve safety. Policies and procedures were in place to promote the safety of staff when working alone within the community.

People were very happy with the availability of staff when they attended for their appointments. They had not experienced any cancellations or delays and had access to staff outside of the usual clinic times for emergency advice and support.

Staff had access to a dedicated training team who provided specialist training opportunities and support to them. Arrangements were in place so that staff could reflect on their practice and develop their competencies.

People were referred to a range of healthcare professionals to maintain their health and wellbeing, including effective pain and symptom management. Additional support was available via well-being clinics, physiotherapy and bereavement support if people wished to access this.

People told us that staff were compassionate, patient and listened to them. People had positive relations with staff which reassured them when attending for treatment.

Staff obtained consent from people before treatment commenced. Staff worked collaboratively with other providers where people's capacity to consent to treatment was not clear. Decisions regarding people's resuscitation status were known and recorded to protect their decision making.

Staff provided advice and support to people to manage their diet where this was part of their treatment programme.

People had a flexible service designed to respond to their needs which included out of hours support to obtain advice and support with their condition. Appointments were arranged to suit people's personal commitments. Links with other providers and educational and promotional initiatives had resulted in improved awareness and referrals so people's condition was recognised earlier. These initiatives were implemented to respond to people's diverse needs.

People felt the service was well run and that they had opportunities to comment and influence the quality of the service provided. The provider demonstrated a strong commitment to developing a specialist Lymphoedema service and staff were fully committed to this vision; evident through the range of promotional community events they had implemented.

There were systems in place to monitor the standards of the care and treatment provided. Regular management meetings took place to review all aspects of the service provided and the results of this were cascaded to staff to ensure improvements were implemented. The provider service worked collaboratively with local and national hospice providers to monitor the effectiveness of their Lymphoedema service which is part of their palliative and end of life care services.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement** 

The service was not consistently safe.

The arrangements in place to manage people's dressings and prescribed creams were not consistently safe.

Staff had been trained to recognise and respond to any actual or potential abuse.

Where risks to people had been identified by external/community health care professionals these had been shared with the service and followed by staff to ensure risks were managed.

There were sufficient numbers of skilled staff to meet people's needs. People had not experienced cancellations of appointments or delays and out of hours support was available.

### Is the service effective?

**Good** 

The service was effective.

People received treatment and support from staff who had the specialist skills to meet their needs. Staff were supported to develop their knowledge and skills via regular supervision and appraisal.

Staff understood the need to gain people's consent and worked collaboratively with other health care professionals to ensure people's rights were protected.

People had access to dietary advice as part of their treatment plans.

People received support to manage their pain and other symptom's via their own GP. Effective communication and links with other organisations ensured decisions regarding end of life care and support were known.

### Is the service caring?

**Good** 

The service was caring.

People's dignity and privacy was respected. Staff were compassionate and caring and people felt staff listened and involved them.

People were actively involved in making decisions about their treatment. People valued the meaningful relationships that were developed with staff.

### **Is the service responsive?**

**Good** ●

The service was responsive.

People had a flexible service which provided out of hours support and appointments could be arranged so people had a personalised plan.

Links with other providers, educational and promotional initiatives had resulted in people's condition being recognised earlier.

People received information on how to raise concerns and complaints.

### **Is the service well-led?**

**Good** ●

The service was well-led.

The service promoted a positive and open culture and opportunities for people to comment and influence the quality of the service provided.

There was effective leadership and a clear strategy for the continued development of the service.

The provider worked with other healthcare professionals and had a strategy to develop specialist Lymphoedema services.

# Wolverhampton Lymphoedema Service

## **Detailed findings**

### Background to this inspection

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

This inspection took place on 5 April 2016 and was unannounced.

The inspection was carried out by one inspector, a member of the CQC pharmacy team, a specialist professional advisor and an expert by experience. The specialist advisor had experience working as a nurse within the community and within the field of palliative care. The expert by experience had experience of using healthcare services.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was completed and returned to the Care Quality Commission. We found the information in the PIR was an accurate assessment of how the service operated.

We also reviewed the information that the provider had sent to us which included notifications of significant events that affect the health and safety of people who used the service.

We spoke with six people who were accessing the Lymphoedema service for treatment on the day of the inspection. We spoke with a patient receiving Lymphoedema treatment on the local hospice ward. We spoke with the Director of Clinical Services, the Quality and Governance Manager, three nurses, one health care assistant, the head of education and training, a lecturer/practitioner, a clinical nurse specialist and the estates manager.

We viewed nine people's records to see how their treatment and support was provided. We looked at the arrangements for managing people's prescribed dressings and treatments to check these were managed safely. We also looked at the arrangements in place and records for staff recruitment, training and quality assurance audits. We viewed feedback from patient surveys.

## Is the service safe?

### Our findings

People told us that they were happy with the support they received to manage their condition and with access to the dressings they needed. One person told us, "I have all the necessary support and bandages that I need at home but if I forget some they have a stock here for me". People maintained control and responsibility for their own medicines in their own homes. Items (dressings or creams) that were needed for a specific individuals' treatment at the clinic were requested from the persons GP via a letter from the clinic. A supply of dressings and topical creams were kept at the clinic although we found these were stored in two unlocked cupboards. A small supply was kept in each treatment room. We found that a number of prescribed items for people were in the cupboards along with stock. There was no process in place to keep items that had been prescribed for individual people separate from the stock. A nurse confirmed that these items had been "used for treatment". Prescribed items cannot be used for people they are not prescribed for. This means that some prescribed items for named people had been used on other people. Following discussion with staff these items were removed from the stock cupboard.

Items with a short expiry date (creams) were not always dated when they were opened or disposed of when their expiry date was reached. Although we did not see these creams being used at the time of our inspection, there was an increased risk of items being used longer than the expiry date and the preparation may no longer be effective. Staff were unable to explain why this was not done and following discussion removed these items from the stock cupboard. We found there was no expiry checking process in place. Some staff did not realise these items had expiry dates on them. It was unclear from the policies available to staff what processes staff should be following as the policy was not specific to the clinic. The director of nursing took immediate steps to remove out of date items and separate stock. She told us they would audit and review medicines use and introduce a process to monitor stock usage and ensure only appropriate stock was kept, properly labelled and in date. We were also informed they would review their medicines management policy to ensure it was explicit in its guidance to the lymphoedema clinic. The director told us they would restructure the pharmacy committee and ensure pharmacy covered the lymphoedema clinic practices.

People we spoke with told us that they felt safe when receiving treatment from staff. One person told us, "I had lost my mobility and confidence and coming here I get loads of reassurance and advice and I feel safer now walking". Another person told us, "I always feel safe with staff and they are careful when they help me onto the treatment bed as my mobility is quite poor". A person told us that as they were unable to drive following treatment they utilised the volunteer driving scheme and said, "The course of treatment I'm having means that I can't drive so they have provided transport. He (the driver) even makes sure that I get into the house safe and well, so that's a brilliant service for me".

Staff explained how they protected people from the risks of harm or abuse. We saw examples of where they had recognised the signs of potential harm such as neglect and the action they had taken to report and escalate this to senior staff and external agencies for investigation. One staff told us, "I have seen patients where I have had concerns about their welfare and safety; one patient's dressings were wet and unchanged which I reported". We saw from records that immediate action had been taken to provide new dressings to



the person. Action to advise and educate external staff caring for the person had also been taken so that they understood how to seek support from district nurses for the person concerned. Staff we spoke with were clear about their role and responsibilities in safeguarding people and had the training to do so.

People told us that at their first consultation staff went through their medical history and needs with them to identify any related risks to their health. A person said, "The clinic staff on my initial consultation went through everything with me and informed me of what was going to happen, (with my treatment) and then provided me with lots of material to read. I can call the clinic anytime if I have any concerns or worries". A nurse told us, "An assessment of people's needs takes place at their first appointment and treatment is planned with them. This includes identifying any risks to their health such as deteriorating mobility, skin care, or their nutritional intake". For some people these risks had been assessed when people had been an inpatient on the ward of the local hospice. These risks were recorded on their electronic records to alert staff at the Lymphoedema clinic. Nurses told us how they promoted people's safety by advising patients how to manage their condition. One nurse told us, "We discuss as part of the patients treatment, the importance of good skin care routines, exercise, healthy eating and how patients should manage their Lymphoedema. We saw that preventative actions to reduce risks to people were described in their treatment plans. For example a person we spoke with told us they were at risk of developing pressure sores. We saw that they were provided with a pressure relief cushion to protect their fragile skin during the course of their treatment. Staff were knowledgeable about people's needs and the specific support required by them. Staff told us that people's treatment, progress and any related risks were communicated to the nursing team each day prior to the start of appointments. Staff demonstrated to us they were knowledgeable about the level of risk related to the people they were treating and we saw that alerts were on people's electronic records to inform staff.

Incidents and accidents that took place within the clinic were closely monitored by the registered manager. Staff told us they were encouraged to report any incidents or near misses which occurred. We saw incident forms were completed and reviewed by the quality manager for any trends or patterns. The system in place enabled management to have a good overview on the type of accidents or incidents, and whether these were reportable to outside agencies for follow up. Accident and incidents were discussed in regular meetings and we saw that responsible staff had implemented effective preventative measures to prevent reoccurrence. For example as a result of a patient hitting a road ramp in their car the estates manager improved the external lighting along the drive.

The provider recognised the potential risk to staff who attended people outside of the clinic environment. There was a lone worker policy in place and we saw staff followed the procedures by signing in and out of the building. Staff had access to mobile phones and told us they were expected to record their whereabouts and expected time of return.

People told us there were always enough staff at the clinic to meet their needs and deliver their treatments. Staff told us there were enough staff to meet people's needs and that there was rarely a delay in appointment times. A person using the clinic told us, "The appointments are mainly on time sometimes I have to wait a few minutes but that's okay with me". We saw that when people arrived for their appointments staff took the time to welcome them and offer them refreshments. We did not see any body was being rushed or hurried. Staff recognised the importance of providing reassurance to people and told us that during their treatment people valued the opportunity to talk with them. One person said, "I can take my time in telling staff how I have been since they last saw me; they never rush me but sit and listen to what I'm saying". We saw that consultation times took into account people's specific needs. During our inspection we observed that any increased risks were considered when staffing the clinic. For example we saw a patient who needed additional support because of their mental health needs had two nurses allocated to deliver

their treatment and a longer appointment time. We also saw that where additional staffing was needed to support a person with their mobility, two nurses had been allocated to ensure the person was supported safely. Staff told us they provided additional time to people between their appointments. We saw that a monthly self-help group coffee morning took place. A person who had attended this said, "There's a member of staff at hand if we need any help or have questions to ask, it's a great idea as they have time to spend with us". We saw in information leaflets that people were advised if they telephoned for assistance during clinic times an answer machine was available from which nurses retrieved messages throughout the day. It advised people they would receive a reply within 24 hours to address their concerns. A person told us, "I have been attending the clinic for some months now, my appointments have never been cancelled or altered which is quite refreshing for me and I know they are supportive when I need them".

We saw safe recruitment procedures were followed which included criminal checks through the Disclosure and Barring Service (DBS). Nurse's registration was checked to confirm they were safe to provide treatment to people. We saw volunteers helped to support and complement the care people received. Staff told us suitability trained volunteers helped people in different ways, such as transporting them to and from the clinic, suitable checks had been carried out on volunteers to ensure their suitability. This ensured people could be confident that staff were fit to carry out their duties.

## Is the service effective?

### Our findings

People we spoke with did not have any concerns with the ability of staff to meet their needs when they attended the clinic for their treatments. One person told us, "I sometimes see the nurse but I do get support from the care assistant, they all know what they are doing". Another person said, "They manage my health issue very well. I never knew this service existed, it is a horrible condition, thank goodness staff know how to manage it".

Staff told us they had an induction that provided them with the skills they needed to meet people's specific needs. One staff member said, "There's an excellent induction programme, I had a full set of competencies which had to be signed off with my mentor and access to an abundance of training". The provider had implemented the new care certificate which is a set of core standards for all staff. We saw staff had as part of their induction, received training in palliative care, bereavement and core training in Lymphoedema to ensure staff had the specific skills needed to support people with this condition. Staff had been supported and encouraged to complete specialist lymphoedema training with some staff achieving additional qualifications in manual lymphatic drainage therapy, [a specific form of treatment]. This enabled staff to provide specific treatments to people who required this treatment to manage their condition.

Training in advanced communications and decision making was provided to ensure staff had the knowledge to work alongside people who may have to consider difficult decisions about their care or treatment. A new member of staff told us how impressed they were with the induction process and said they felt they knew exactly what to expect when they started to work independently.

Staff told us they had regular supervision and support. We saw weekly practical sessions took place in which staff could refresh their skills. For example the previous week they had checked each other's compression dressing pressures to ensure this was being correctly applied to manage people's symptoms. A staff member said, "We have yearly lymphatic drainage sessions, [specific treatment methods] so that we can keep up to date with our specialist skills and knowledge".

Staff development and learning was supported by a dedicated education team who provided a variety of training for all staff as well as specialist training to external organisations. There was a range of specialist subjects available and links with the local university were in place to support specialist training. In addition there were staff who were lecturer/practitioner trainers on site who worked part of their time alongside staff. This enabled them to provide practical opportunities for staff to develop their clinical skills. Lead roles were evident; a manual handling coordinator and infection prevention lead also provided training. Staff with lead roles had the training needed to support other staff in their development. This ensured people were supported by staff who had the skills to meet their needs. Staff we spoke with were positive about the availability of training and the support they received. One staff said, "If there was any aspect we need to know they would provide it". We saw staff could continue their professional development to degree level. Staff told us they had annual appraisal to reflect on their performance and identify their future training needs. A nurse told us the annual appraisal provided an opportunity to reflect on their practice and to plan objectives to further develop their skills. There were opportunities for staff to take part in reflective practice

where they could talk about how they had managed situations and improve the experience and care of people using the service.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In this service applications must be made to the Court of Protection. We checked whether the service was working within the principles of the MCA. There were no Court of Protection orders in place for people attending the service. Staff within the Lymphoedema service followed the risk assessments developed by health care professionals with primary responsibility for the provision of a person's care. Whilst staff may be involved in any best interest decisions, other agencies that were the primary lead in people's care would be responsible for making any applications. We saw staff would be alerted to any such decisions via the electronic records system. We saw people had consented to their treatment and this was captured on their treatment records. One person told us, "I was quite happy to consent to treatment because everything was explained to me first". A nurse told us, "We always discuss treatment, explain options and choices and ensure the patient knows what is happening before any treatment commences". We saw that staff communicated with people during each stage of their consultation to ensure the person was happy to continue. Staff told us that if they had any concerns about a person's deteriorating capacity they would communicate this to their own GP to ensure a coordinated approach to the person's needs. Staff had received training in relation to the principles of MCA and DoLS. There was a designated MCA and DoLS champion who attended a local steering group. The MCA lead had presented an MCA and DOLS awareness training session which was attended by members of the public, patients and staff, enabling people to seek advice about this legislation.

We saw that where people had made decisions in relation to resuscitation, a record of this was evident on their electronic treatment records. These showed that 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) was in place. Staff said that they would always know people's preferences with regard to their resuscitation before they commenced treatment at the service. A staff member said, "If someone's condition was deteriorating we would have conversations with them to ascertain their wishes".

People maintained responsibility for their own nutrition and hydration. The Lymphoedema service did not provide meals. Drinks were freely available for people whilst they attended for their appointments. One person told us, "They always offer refreshments; I have a cup of tea whilst I'm here". Staff told us that as part of their initial assessment of people's needs information on nutrition and hydration was considered. We saw that people's initial assessment prior to their treatment included risk assessments that had been completed whilst the person was an inpatient at the local hospice. Identified risks related to nutrition or hydration were evident on people's electronic records to alert nurses. We also saw from consultation records that advice was provided to people with regard to their diet or hydration.

Referrals to the Lymphoedema service can be made by the person themselves, their GP or by health care professionals from the local hospice where people may have been an inpatient. In each instance staff liaised with the person's general practitioner to ensure that the service was able to work collaboratively to provide the best care. This promoted a joined up approach to care in order to provide on-going health care support to people. One person told us, "My GP is always consulted and information is shared, the staff here are great; they communicate well with other professionals".

Staff worked as part of a team of health care professionals. A range of healthcare professionals were available to people attending the Lymphoedema service via the local hospice. Staff told us they could refer people quickly to various departments where their health needs indicated this was needed, for example to the wellbeing service, healthy lifestyles or the physiotherapist. We saw that people were also referred to external healthcare professionals when necessary. We saw peoples' individual health needs were discussed by the team to ensure a multidisciplinary approach was adopted. Effective communication and links with GP's, district nurses and other organisations that provide palliative and end of life care and support were evident so that all the services worked together to ensure people's healthcare needs were met. One person told us their experiences of the service, "After being an inpatient I was discharged and had a district nurse visit me at home. I was referred here for on-going treatment. My GP was fully involved and I have no complaints about how they arranged my care".

People received support to manage their pain and other symptom's via their own GP. Treatment plans included pain and symptom management. Staff told us they helped people to ensure their feelings of pain were managed and controlled so that people were as comfortable as they could be. One staff member said, "If a patient needs pain control it is done via their own GP but we can liaise with their GP to report any changes or concerns. We would always check with people about their pain and discomfort". A person told us, "My GP continues to monitor my progression and is pleased with what they do here for me". Another person said, "I leave here in slight discomfort but I know in a few hours I will feel much better and the relief lasts for about three weeks". This ensured people had the support they needed with their pain or symptoms without unnecessary delay.

## Is the service caring?

### Our findings

Everybody we spoke with was very enthusiastic and happy with the way in which their treatment was delivered to them. One person said, "What a wonderful caring service they provide for me". Another person said, "Nothing is too much trouble and I feel treated as a person not as a patient. I'm more than happy with the service and treatment they give me". People were consistently positive about the caring approach of staff. They described them as being patient and thoughtful and never rushed them.

People told us staff always made time to talk to them and listen to them during their treatments. One person said, "I'm usually here about an hour and the nurse is always lovely; I can talk to her discuss my concerns and she listens, I think the staff are marvellous". People described positive relationships with the staff who supported them at the clinic. One person told us, "I always see the same nurse; you wouldn't get that anywhere else. She knows me and I feel I can confide any worries in her because we have a good relationship".

We saw when people arrived at the clinic that they were greeted in a friendly and polite manner by both the receptionist and the staff who arrived to treat them. During our observations we saw staff were polite, respectful and helpful when assisting people to the treatment rooms. People told us that staff were always respectful. One person told us, "How can I describe my care here? It's a day out with treatment. They treat me with respect. I have been coming here for such a long time I know all the staff and they know me too so they know what treatment I need, which is lovely and uplifting for me".

People's privacy and dignity was respected. People told us that their treatment was always carried out in a private treatment room and that nurses always closed the doors. One person said, "The staff are very respectful when I need to undress and will cover my body, only the part being dressed is exposed". Another person told us the treatment rooms offered privacy, "I can discuss my care with confidence as no one else can hear what I'm saying". We observed that staff showed respect for people and managed their anxieties and answered their questions. One person told us, "Staff listen to what I say and I feel they respond with compassion and great care. When I ask questions they normally have the answers for me if not they go and find out there and then".

Staff were experienced and skilled in identifying when people needed emotional support. We saw from records that discussions between them and patients regarding their well-being had taken place and included looking at the impact the condition had on a persons' life. A nurse told us, "People can suffer socially and emotionally; we offer advice about managing their condition and we can refer people to other services for support such as physiotherapy".

People were fully involved in the planning of their care and treatment. They told us they were consulted on each visit to the clinic to review their progress and needs. We saw there was consistent involvement with people about their preferences and wishes in regard to their care, support and treatment. For example one person's goal was to; 'Be able to put my shoes on' and we saw their feedback; 'I feel the treatment is working'. Another record showed staff had supported the emotional well-being of a person by explaining the

importance of wearing their compression garments. The person had been very emotional and we saw staff had reassured them about the treatment and how it worked. We saw that a personalised treatment programme had been arranged for a person. This caring approach took into account their role as a carer. This recognised the anxiety of the person and helped to reduce the risk of them not completing their treatment by arranging treatment times to suit their needs.

We observed a staff and a person discussing treatment and the person was encouraged to express their views and make their own decisions. We saw the nurse involved the person, enquired about their pain levels and carried out a physical examination for signs of skin breakdown. The nurse ensured the person had explanations about their treatment throughout their consultation.

Some people had made decisions about their end of life care. Advance decisions were recorded and effectively communicated to staff at the clinic. Staff we spoke with were aware of people who had an advanced care plan in place and this was evident on the electronic records they held for each person. We saw that staff from the clinic supported some people with their lymphoedema who were receiving treatment as an inpatient at the local hospice. Staff told us that where they supported people with an advanced care plan in place they were supported by the specialist palliative care team. We saw when people had expressed their wish about resuscitation this was appropriately recorded and staff were made aware of people's wishes.

People told us they were encouraged to keep their independence and control in as many areas of their life as possible. One person told us how they had been helped to obtain equipment to use at home to ease their discomfort. We saw people could loan pump and massage machines to provide relief in their own home and to independently manage their condition.

People had access to a range of information about the services provided. Information leaflets about Lymphoedema were easily accessible. People told us they had attended sessions to learn about the treatment options before commencing treatment. We saw group information sessions had been introduced last year as a result of people's feedback. The sessions provided people with information about Lymphoedema. Staff told us this 'bridged the gap' between referral and assessment so that people's potential anxieties could be addressed. We saw evaluation forms of people's feedback described these sessions as useful and informative and helped them to understand the forthcoming treatment programme. We found this was a positive way of trying to manage people's anxieties.

A range of support services were available across the hospice to suit people's preferences and needs. People could be referred internally by staff to access complementary therapy, physiotherapy and support from the social work team. A wellbeing team, spiritual care and bereavement support was also available. The people we spoke with told us they knew they could access these services but did not need them at this time. We saw from treatment plans that people had utilised some of these services where it was beneficial to their treatment programme. For example some people had used the physiotherapist and gym and wellbeing team to manage issues with their weight and to develop healthy lifestyles. Counsellors and social care teams could see people when they visited the clinic for their treatment. This ensured people's worries and concerns could be discussed with them whilst they were at the clinic. Information about advocacy services was available to people. Staff also told us if people needed this support they could refer them to the social work team or directly to advocacy to make sure they had the help they needed.



## Is the service responsive?

### Our findings

People consistently told us staff were responsive to their needs. One person told us, "The staff are knowledgeable and have provided me with information and leaflets and things like that so I understand my illness". Another person said, "I was struggling with my condition and getting quite depressed but since the treatment I am much more confident and hopeful".

People told us that they had been well informed about what the treatment involved and had been asked about any difficulties this presented for them. Treatment plans did reflect how people wanted and needed to receive their treatment and support so that they had as much choice and control as possible. We saw staff took into account their personal circumstances and the impact it had on their lives. For example staff had responded to the difficulties being experienced by a person who was at risk of their condition deteriorating because they were not regularly attending for treatments. They were provided with a volunteer to transport them and chaperone them. This enabled the person to receive their treatment consistently; preventing their condition deteriorating and to reach their personal goal which was to reduce swelling to their legs and improve their mobility. This ensured that the person's treatment was organised in a way that met their needs.

People told us how staff were responsive to their needs. One person said, "They are full of information and advice and make the time to talk to me about my worries; I've gained a lot of confidence and my condition is improving". People's treatment and care records included information about their personal history and individual preferences. We saw these were used to make sure that they received care that was centred on them as an individual. One person told us, "If I see someone new they are aware of my medical history which I find reassuring". Records of treatment showed the impact on the quality of people's life. For example staff had arranged a person's appointments around their personal commitments at home. This ensured the person was able to complete their treatment programme within an agreed timeframe without interruption. This had helped to reduce the stress of their personal commitments being affected by their treatment programme. A person told us that attending the clinic helped them to cope with their diagnosis and the practical aspects of their day-to-day lives. They said, "They provided information on the type of exercises that I need to do at home which helps me in my discomfort and helps keep me mobile". Another person said, "There are people here who can advise you with personal matters, sort out equipment, it all helps when living with this condition".

Care and treatment was discussed daily by staff at the start of the day. Staff told us this allowed them to share and discuss any changes or updates in people's treatment needs. We saw staff also completed and updated electronic records whilst they were with the person following their treatment. Any changes or information from other professionals involved such as their GP, district nurse, breast care nurse, consultant or staff from other departments within the local hospice were captured. This ensured people were at the centre of the care and changes to their treatment were well communicated to their GP and where necessary, other departments at the local hospice.

People told us they had been signposted to services provided by the local hospice as well as community



support groups. They could have access to the social work team if they needed financial or practical help. The social work team provided counselling and bereavement support. Staff told us that they would refer people to relevant services within the hospice if they chose to use these. This included support with well-being, healthy lifestyles or physiotherapy. We saw staff discussed these options so that people were informed about what was available to them.

Questionnaires had been completed by people and as a result of their feedback we saw staff had been responsive to people's needs. For example and 'SOS' clinic had been started as a result of people's feedback. This enabled people to access specialist nurses and advice therefore ensuring a rapid response to their changing care needs.

Staff had focused on people's individual needs and arranged care and treatment in a way that was personal to them. For example a person experiencing difficulties with bathing had been assisted to use the onsite shower facilities. This enabled staff to remove dressings and replace them after the person had showered. This showed that staff were responsive and tried to ensure the care and treatment focused on the person's individual needs.

Staff took a key role in the local community actively building links with other healthcare providers. Staff told us how they held a yearly awareness week every March. They took an education facility called the 'Compton bus' to GP surgeries and presented educational videos and sessions to a range of healthcare professionals in order to aid their understanding and raise awareness. One staff told us, "We take our bus around to different locations and it has made a difference, we can see an increase in some GP's making referrals where previously they had not". We also saw staff had provided training aimed at staff in care homes. The training session; 'Just a Bit of Swelling' was designed to raise awareness amongst care staff of how they might recognise Lymphoedema and seek appropriate referrals to the service. This initiative helped to ensure people were referred to the service without delay because their condition was recognised by staff in the care homes.

The provider had hosted a conference directed at meeting the needs off and reaching out to 'hard to reach groups' such as homeless people. We also saw they had initiated a palliative and end of life care prisons project. This was aimed at improving end of life care for prisoners. This project included raising awareness amongst prison healthcare staff and prison officers in recognising and responding to people's specific needs. The findings of this project had been shared at public conferences and we were told had led to lead roles being developed around the country to support people with end of life needs who were in prison. A recognised award for their work had been received. Staff told us more people from secure environments were presenting as in-patients at the local hospice and that if part of their treatment included Lymphoedema care they would support this on the ward under the direction of palliative care consultants and nurses.

We saw a range of compliments from people and healthcare professionals in response to a film that had been produced by staff at the Lymphoedema clinic. The film had been produced to raise awareness of Lymphoedema within the wider community. One person commented that they were pleased to see the film as they had just been diagnosed with Lymphoedema following treatment for cancer and found the film educational. Another person commented that the film was raising awareness of the condition and would help with early diagnosis. We saw a range of feedback on social media complementing the staff for the informative and well-presented video.

People we spoke with had no concerns about the service and had not raised any concerns or complaints. People told us they would raise any concerns with staff. We found from speaking with staff that they had a

clear understanding of the procedures around handling complaints and how to escalate these. Complaints were discussed at governance meetings so that they were shared with senior managers. We saw a complaints had been recorded, investigated and a written response had been sent to the complainant. The complaints recorded did not relate to the Lymphoedema service but other departments within the local hospice that people had utilised. Therefore we were confident if this service received a complaint they would know how to effectively respond to matters.

## Is the service well-led?

### Our findings

People were all very positive about the care and treatment they received. One person told us, "It's a very good service; staff are kind, friendly and help me with my condition, I think it is well run".

There was a clear management structure within the service. The registered manager had retired a few days before the inspection so interim arrangements were in place until a new manager could be appointed. The Lymphoedema service was nurse led with support from nursing staff and health care assistants. Our discussions with staff showed they were motivated, enthusiastic and committed to providing a high quality service to people. This was well demonstrated via their commitment to the promotional work they had undertaken. Wolverhampton Lymphoedema service had been promoted within the local community via the awareness events, training and video technology staff had provided to people who may wish to use the service as well as other healthcare professionals within the community. This had raised awareness and increased early recognition and diagnosis of the condition.

Links with health and social care providers and professionals to promote good practice were evident via the training and learning events the Lymphoedema service had made available to them. Staff had access to a dedicated education team who provided a variety of training including specialist training in the management of Lymphoedema. In addition there were lead roles for specific staff in specialist areas where they had specialist training in manual lymphatic drainage therapy; [an alternative method of managing people's lymphoedema]. This ensured staff had the specialist skills to meet people's needs as well as to share their expertise with their colleagues. All staff had access to training in symptom management, end of life care and communication. Staff told us they were very happy working at the service and felt supported with their professional development.

Questionnaires completed by people using the service reflected that people had been given the opportunity to comment upon the service. We saw that their feedback had been used to make improvements such as developing the 'SOS clinic'. This showed that the management and of the organisation used people's feedback to try and deliver a service that was person-centred and responsive to people's needs.

There were effective systems in place to ensure staff received information about the service. Staff told us they had daily meetings, supervision and email alerts. They also attended staff meetings to share ideas and discuss their practices. There were dedicated annual away days with staff to discuss the development plans for the service. One staff said, "It's a great organisation and our focus is on promoting Lymphoedema care; we are always consulted".

Staff understood their responsibility for reporting any concerns regarding colleagues' performance. Whistle Blower procedures were available to guide staff. One staff said, "Any concerns would be escalated, there is a no blame culture but we would report and investigate any concerns". Staff demonstrated their commitment to providing people with a safe and caring service.

The provider had actively sought to promote a positive culture that is open and inclusive to people who use

the service and staff who work at the service. The provider had commissioned an external company to conduct a staff survey; we saw the results of this were predominantly positive with staff stating they enjoyed the work they did and were happy with the standard of care they provided.

The provider was aware of their responsibilities to report significant events to the Care Quality Commission. The provider information return, (PIR); was completed and returned to us in a timely manner. The PIR accurately reflected the service being provided and identified the provider's plans for the future. We saw from the PIR that they recognised some areas that they wished to develop further, for example to improve staff communication by setting up a staff forum. We also saw that they had plans to develop specific leadership training for staff in leadership roles. These reflect aspects of a well-run and effective service aiming to demonstrate their commitment to improvements in service provision. The provider had identified priorities for the forthcoming year which reflected their vision for specialist Lymphoedema and end of life care by strengthening their links with other partner organisations. They had links with Breast Care, Head and Neck and Vascular Services at the local hospital and aimed to build on this to ensure other services promoted earlier referral to the Lymphoedema service for people who needed this.

Leadership of the service was evident through regular committee meetings involving the heads of all departments. Meetings between the director of nursing, chief executive, medical director, finance and quality and governance leads were held weekly and this enabled them to review the quality of the service provided. Regular audits had been carried out on such as; medicines, infection control, and the environment. These were then shared with senior managers at board meetings for consideration. A pharmacy committee met monthly but did not include an overview of the Lymphoedema service and audits for the management of people's prescribed treatments had not identified the shortfalls we identified. The issues we identified in relation to the management of people's prescribed treatments showed that there were gaps in the clinical leadership and governance of the service. The director of nursing told us that as a result of the medicine shortfalls they would restructure the pharmacy committee to ensure they include an overview of the Lymphoedema service.

The provider worked in partnership with other key organisations including the clinical commissioning group. There were quality indicators which were used to benchmark safety and quality at both regional and national level to compare their performance with other Lymphoedema services. We saw they attended annual conferences for hospices and regional meetings with local hospices to share and discuss best practice initiatives. We saw there were arrangements in place to cascade information about key issues to relevant staff and managers.

The provider was continually seeking to strive for best practice. For example the provider had implemented lead roles such as the Mental Capacity Act (MCA) lead. As a result of this initiative the MCA steering group presented an MCA and DOLS awareness training session which was well attended by members of the public, patients and staff, enabling people to seek advice about this legislation. The staff members who had lead roles were trained and offered on-going support to improve their and staff knowledge to benefit people using the service.