

Marie Curie

Marie Curie Hospice Hampstead

Inspection report

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11 October 2016
12 October 2016
13 October 2016
14 October 2016

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

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 in 10, 11, 12, 13 and 14 October 2016 and was announced. When we last visited the hospice on the 26 August 2014 we found the provider was in breach of the regulation relating to the need for consent. They had sent us an action plan and had told us they would make the necessary improvements to ensure that all care records would appropriately reflect that people had consented to their care. During this inspection we noted that the provider had made suitable arrangements to obtain, and act in accordance with the consent of people in relation to their care.

Marie Curie Hospice Hampstead is one of the hospices in the Marie Curie group providing palliative and end of life care for adults only. The hospice could accommodate up to 34 people. There were 30 people using the hospice at the time of the inspection. Staff specialise in helping people with life-limiting illnesses including cancer, motor neurone disease, heart disease and renal failure. Treatments and care offered include inpatient care and rehabilitation, day therapy and outpatient appointments.

Other services offered by the hospice included complementary therapies, outpatients, physiotherapy, spiritual support and bereavement support for families, friends and carers of people using its services.

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

People told us that they were safe and protected from potential abuse. Risk assessments and appropriate management plans were in place where risks were identified to protect people from potential risks from receiving care. Staff were available in adequate numbers to meet people's needs. Staff had the training and support needed to ensure they were skilled and knowledgeable to meet people's needs.

People received their medicines safely and as prescribed. There were appropriate arrangement in place to ensure the safe management of medicines, although we identified a few issues that the management team told us they would address promptly. The hospice worked to ensure that people's health care needs were met by a multidisciplinary team of health professionals.

People were supported to make decisions and choices about their care. Where people were unable to make decisions about their care their human rights were protected as assessment had been carried out to make sure any decisions were in their best interests.

Care plans reflected people's needs and their preferences. Staff understood people's care needs and provided care and support in a person centred way. People had a choice of meals that met their nutritional needs and reflected their cultural or religious preferences.

People were treated with kindness and compassion. Their dignity was respected as care was delivered to meet their individual needs.

People knew how to complain and there was an accessible complaints policy to guide them through the process. People were confident that their concerns would be addressed.

People were consulted and involved in making suggestions for improving the service. The quality of the service was monitored and action was taken to improve the service when necessary.

People, relatives and staff told us that the registered manager and the management team were accessible and listened to them. People and staff were involved in the development of the service as there were ways for them to share their views, and make suggestions to improve the hospice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service provided was safe. Staff had been trained and knew how to protect people from abuse.

Risks assessments identified risks to people when receiving care and how these were to be addressed.

Staff were available in sufficient numbers to meet people's needs.

Medicines were managed safely.

Is the service effective?

Good ●

The service was effective. Staff had the necessary skills, received regular training and understood how to care and support people.

People received a variety of meals that meet their dietary needs and individual choices and preferences.

People's consent to care was sought and the necessary safeguards were in place if they could not consent to their care.

People's healthcare needs were addressed as staff ensured they had access to the appropriate health care professional to meet their needs.

Is the service caring?

Good ●

The service was caring. Staff were caring and knowledgeable about the people they supported. People told us they consistently received care that met their individual needs.

People's privacy and dignity were respected. People and relatives were supported by staff who were kind, compassionate and caring.

People were supported to make informed decisions about their care and support.

Is the service responsive?

Good ●

The service was responsive. People's care plans provided detailed information about how their needs were to be met.

Staff supported people so that they received care that met their needs and preferences.

People's complaints were addressed appropriately.

Is the service well-led?

Good ●

The service was well-led. People and their relatives were asked for feedback and this was used by the provider to improve the service.

The provider had ways to assess and monitor the quality of the service so improvements could be made where identified.

The provider promoted an open and transparent culture in which good practice was identified and encouraged.

Marie Curie Hospice Hampstead

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 10, 11, 12, 13 and 14 October 2016 and was announced. We gave 48 hour's notice of the inspection due to the complexity of the service. The inspection team consisted of a lead inspector, a pharmacist inspector, a specialist professional advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection, we asked the provider to complete a Provider Information Return (PIR). The PIR 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. We reviewed the information we held about the service. We also received feedback from two external palliative care specialists, Camden Healthwatch and one commissioning officer from Islington. Healthwatch England is the consumer champion for health and social care.

During the inspection we spoke with 13 people who used the service, four relatives. We also spoke with 10 members of staff and three volunteers. This included the registered manager, facilities manager, clinical lead nurse, ward manager, supportive care services manager and head of quality improvement, who was in the hospice on one of the days of the inspection. We spent time in the inpatient and outpatient wards, observing care and support. We joined a multi-disciplinary meeting.

We looked at six people's care records and 10 medicines records. We looked at other records relating to the management of the hospice. This included five staff recruitment records. We also looked at staff duty rosters, accident and incident reports and records relating to complaints, compliments, health and safety,

maintenance, governance and quality monitoring.

Is the service safe?

Our findings

People confirmed they felt safe at the service and knew that they could raise any concerns they had about their care with the provider. One person said, "They [the staff] are nice here, there are always nurses around and that makes me feel safe." Another person commented that the service was, "Very safe, the whole place makes me feel safe." Information was available advising people about what they could do if they had concerns regarding the service. There had been five safeguarding alerts in the past year. These had been referred to the local safeguarding adults team and investigated appropriately. The provider had addressed any recommendations that were made as a result of these safeguarding investigations.

Training records showed that staff and volunteers had completed safeguarding training. The provider had systems in place to detect and prevent abuse. They knew how to and when they should report potential abuse. They also knew who to report abuse to and how they could escalate concerns to other organisations such as the police, local authority safeguarding teams and the Care Quality Commission. One member of staff said, "Safeguarding is keeping people safe from harm and abuse. I would report these things to a manager."

The majority of people told us there were sufficient staff available to meet their needs. One person said, "There are always nurses around and that makes me feel safe. However, two people on one of the wards told us call bells were not answered promptly. We raised this with the registered manager who told us they would ensure that staff were aware of the need to answer call bells promptly. We saw that staff responded to people's needs in a timely manner and were available when they needed care."

The provider took whistleblowing allegations seriously and dealt with them appropriately. Prior to the inspection we received a whistleblowing concern relating to the admission of certain patients and alleging that the hospice was admitting people whose needs could not be met. The registered manager told us that a similar whistleblowing had been received in 2014. They were able to show us a report outlining how they had responded to these concerns.

There was a robust and detailed recruitment process that ensured only suitable staff were appointed to work with people. We looked at five recruitment files of staff recently appointed to work at the hospice. These contained the relevant recruitment checks such as employment references, the right to work in the UK and criminal records checks. Where staff had a professional qualification (for example in nursing) the provider carried out checks with the relevant professional body to make sure their registration was up to date.

Risks that people faced were assessed and addressed to ensure they received care safely. Care records showed that risk assessments were in place and matched with people's needs. These covered the risks of developing pressure ulcers, malnutrition and falls. Risk prevention plans were in place to cover these areas where risks were identified. Staff we spoke with could explain the risks relevant to each individual and how they should respond to them in order to ensure the person's safety. Risk assessments were reviewed regularly according to people's needs. For risks of developing pressure ulcers and falls these were reviewed

daily. Where necessary risk management plans were updated to address any changes in people's needs.

The provider had assessed and put in place systems to manage corporate risks that may affect the continuity of the service and had planned how they would respond to emergencies that might affect the service. The provider had a business continuity plan and carried out exercises using different scenarios to establish whether the business continuity plan was robust. Policies and procedures had been put in place around the management of corporate risk.

Medicines were prescribed by in-house doctors on prescription charts. People's medicines were supplied as stock medicines or on a named patient basis. Medicines came from a local community pharmacy. Staff could obtain medicines between 9am and 7pm, six days a week and there were arrangements to obtain medicines outside these times if required. Medicines were reviewed on a daily basis by doctors and nurses to ensure people were receiving the medicines that they needed, and the pharmacist reviewed prescription charts regularly to ensure there were no errors.

For people who received a service from the outpatients service, there were arrangements for them to receive medicines as necessary. Staff prescribed medicines on an outpatient prescription form that was dispensed at the local pharmacy.

Each ward had a locked clinical room where medicines were stored in locked cupboards. Access was restricted to permanent nurses and pharmacy staff. Medicines for injection were prepared in these clinical rooms. These rooms had close circuit television installed to improve security.

Although medicines (including medical gases and CDs) were stored securely, we noted that the provider was not adequately monitoring the temperatures that these medicines were stored at to ensure they were always stored at the correct temperatures to remain effective. The registered manager told us they were in the process of developing a temperature monitoring template to rectify this.

Whilst the records showed that medicines requiring refrigeration were stored safely between 2°C and 8°C, we saw that the minimum and maximum temperature readings were not being recorded accurately. This was because the readings were the same every day (on both wards that we checked). When we checked the actual temperature from the thermometer we saw fluctuations in the current temperature readings to what was recorded. We discussed this with staff and they said they would seek guidance on how to use the internal fridge thermometer to obtain accurate minimum and maximum temperature readings and to reset the thermometer.

Staff told us that all medicines expiry dates were checked weekly. However during this inspection, five expired sodium chloride 0.9% 250ml bags were found. Staff disposed of them immediately when we pointed it out and told us they would not have used these as they were always check expiry dates before administering these medicines.

Staff had access to relevant facilities for the disposal of unwanted medicines (including CDs and sharps). Patient's own CDs were returned to the community pharmacy for disposal. Stock CDs that were no longer required were denatured and disposed of appropriately. Records were kept of this activity.

People's medicines were administered by registered nurses who ensured they followed medicines administration procedural. For example making sure medicines which needed to be checked by two nurses prior to administration, for example some types of injections and medicines, were appropriately checked. Nurses signed the prescription charts to confirm that medicines were given as prescribed.

We checked the prescription charts for 10 people. Each prescription chart was appropriately completed and clearly written, and we saw evidence that the pharmacist had screened the prescriptions.

We saw one chart where 1g of paracetamol tablets had been given at 10am and again at 1pm. A gap of four hours must be left between doses of paracetamol. This chart was highlighted to the hospice pharmacist on the day of inspection. The hospice pharmacist explained they would ensure that the need to leave four hours between doses is recorded on the medicines administration records.

We saw that anticipatory medicines were prescribed for people admitted to the hospice so that nurses could give them if people became unwell. (Anticipatory medicines are commonly prescribed within palliative care settings. They are medicines used to manage common symptoms that can occur as people reach the end of their lives.) We saw that pain charts were used to record pain scores.

Staff checked medical equipment daily to make sure these were working appropriately to monitor people's conditions. This included the suction machines, blood pressure monitors, pulse oximeters, tympanic thermometers, and a defibrillator. We saw evidence that all blood glucose machines were calibrated daily. This helped to provide assurance that blood sugar readings obtained for people were accurate.

Is the service effective?

Our findings

People said that staff understood how to meet their care needs. One person said, "Staff understand how to help me." Another person told us, "The skill and understanding they [the staff] show is amazing." Staff were able to tell us how their training had assisted them to meet the needs of people.

At our inspection of August 2014 we found the provider in breach of the regulation in relation to the need for consent as people's Do Not Attempt Cardiopulmonary Resuscitation did not record that people or their relatives were fully consulted about decisions relation to resuscitation. The provider sent us an action plan and told us they would make the necessary improvements by ensuring that all care plans showed that people had consented to their care. At this inspection we found that the provider had made suitable arrangements to obtain, and act in accordance with the consent of people in relation to their care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes, hospitals and hospices are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People told us and we saw that staff involved them in decisions about their care and asked their permission before providing any support. People were involved in decisions about their care. Staff told us that they started with the presumption that people could make decisions about their care. Where people could not make decisions about their care staff understood how the Mental Capacity Act 2005 (MCA) could be used to make sure people's rights were upheld.

Staff understood that people's ability to make decisions could change and knew how to make decisions about what was in the person's best interests. Training records showed that staff had received training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Staff told us when and how they would apply for a DoLS assessment. Care records showed that best interests assessments had been carried out in some cases where people could not make decisions about their care, and when necessary a DoLS authorisation had been obtained.

Staff told us they had access to a range of training that enabled them to meet people's needs. Records showed that staff had completed a comprehensive induction which included all aspects of working with people with palliative care and end of life needs. Marie Curie has a national induction programme and staff told us that it had given them a good understanding of how they should meet people's needs.

Staff also had access to training in other areas of palliative and end of life care. This covered areas such as

dealing with bereavement, the management of pain and meeting the physical needs of people at the end of their life. This training was ongoing and a training matrix was in place to monitor training and this showed when staff had completed relevant training and when they were due refresher training.

Staff said, and records confirmed that they were having regular supervision meetings in line with the provider's policy. These consisted of meetings either with their manager or a clinical specialist to discuss their training and development needs. Clinical supervision was provided for staff with a clinical background (for example nurses). Records showed that annual appraisals were taking place to assist staff to identify their training and personal development goals.

Bimonthly Schwarz rounds were being held for staff. These are meetings for staff to reflect and discuss how caring for people who used the service affects them. Staff told us that this supports them to be more sensitive and effective care workers. Staff told us they could discuss any issues regarding how they carried out their caring role and gain support from their colleagues.

People were offered a range of meals each day and could make choices about what they wanted to eat. One person said, "I have lunch here, and it is very good. We get a good choice." Another person told us, "The food here is excellent, we get a choice of menu." The chef showed us the four-week rotating menu, this showed that a variety of meals were provided.

The chef explained that if people did not want what was on the menu they could always request in alternative which they would make. We saw people requesting meals, some of which were not on the planned menu, but which the chef cooked for them as this was their choice.

Care records contained nutritional assessments that outlined people's individual nutritional needs. This included whether they were on a particular diets due to their care needs or whether they had particular dietary preferences resulting from their culture or religious belief. One person said, "The food is very good, I am a vegetarian." A family member told us, "I get my relative to make her own food, I will get it from a kitchen The staff here understand we do this because it is part of our religion." Where people's nutritional support included special feeding regimes, supplements or tube feeding these were recorded in their care plans. These care plans gave details of the specific care that people needed.

Staff supported people to meet their healthcare needs and work closely with other professionals. The advice and information provided by other professionals was included in people's care plans. There was a focus on health and social care professionals working together to meet people's needs as multidisciplinary team meetings (MDT) were held for both the inpatient and outpatient services. MDT provided a forum for professionals to discuss the individual needs of people and share information on the care being provided for them. As part of the inspection we attended two MDT and saw that staff from different professional backgrounds worked together to meet the needs of people who used the hospice.

A number of complementary therapies were provided for people, these included hypnotherapy, acupuncture, cranial sacral therapy, sound bath, Reiki and massage. One person said, "Yes they are fantastic here, I use the gym and I have Reiki which is a healing therapy." These therapies supported people to manage their symptoms, and were included as part of their plan of care.

Is the service caring?

Our findings

People told us that staff treated them with respect, and were caring and kind. One person said, "Yes the staff do know me well and they call me by my first name, the staff are wonderful." One relative said, "They [the staff] have been fantastic." Another person said, "The staff are really kind and caring. I have Parkinson's and it is affecting my speech and my eyesight., and they help me to cope all the time." Throughout our inspection, we observed staff spent time with people talking with and listening to them and responding to their needs. One person said, "Yes, I get chance to talk to the staff."

People and relatives understood the support and services that the hospice provided because staff spent time explaining this to them and providing information as necessary. People told us they had regular contact with staff from the hospice and were involved in decisions about their care. When people had specific issues concerning their care they knew they could contact the hospice and staff would be helpful in supporting and addressing their concerns.

People received personalised care as the hospice met all aspects of their needs. Care records contained advanced care plans and these reflected how people wanted to be cared for at the end of their lives. We saw that people were involved in preparing advanced care plans. Staff knew that this could be difficult for people to discuss how they wished to be cared for at the end of their lives and approached the subject in a sensitive and supportive manner.

People's care plans identified their individual needs and the actions necessary to address these. People had been involved in deciding how their needs should be met. Care plans were reviewed and where necessary changes made to ensure that people received the care they needed. Care records showed that people's needs for psychological counselling support were identified. People could also participate in art therapy to explore their feelings and emotions. People were provided with psychological and counselling support that met their needs and supported their emotional well-being.

People and relatives received compassionate care at all stages of their living with palliative care needs. Relatives were supported to spend time with their loved ones at the end of their life. Staff had the necessary understanding and skills to support people and relatives to discuss their worries. People were supported to prepare how they wished to be cared for at the end stages of their life. This included making advanced care decisions. Staff understood how to discuss advanced care planning with people and relatives.

The hospice provided an outpatients service and this was highly valued by people who used the service. One person told us about the outpatient service that, "The staff here are fantastic and so are the nurses and the doctors. I come on a Tuesday to keep updated with the doctor and the volunteers are fantastic here. They really do look after us." The outpatient service supported people in their daily lives. On their first visit a doctor or nurse carried out an assessment of their needs. This assessment identified possible therapeutic and complementary treatments that people might benefit from. One person said, "My carer got me here and I have been coming here for five months. It's the best place everyone is so caring and lovely. When I come here I do things like go to the gym. And I usually come here twice a week and it has been brilliant for me, I

use the gym and during the week they do other activities as well. They also do group activities." People who used the outpatient service had an individual care plan outlining the therapies that they were going to be engaged with and the reasons why these would meet their needs.

People's cultural and religious diversity was promoted by the service. Staff knew how to support people to express their spiritual needs. Care plans reflected people's cultural, spiritual and religious needs. A chaplain supported by the voluntary chaplaincy team was available to people so that they were able to express spiritual and religious needs. Where necessary the chaplain engaged with relevant local and community faith groups to support people using the service. A multi faith room was available for people if they wished to spend time alone or engage in any other spiritual or religious practices. One relative said, "Yes the staff are very understanding about our religion. We are orthodox Jews and although this is not a Jewish hospice, they have been good and understanding with our religion. We prepare our own food and practice our own ways."

Staff addressed people by their name of choice and tried not to enter people's bedrooms when they had visitors. There was a family room on each of the wards. These provided space for people to meet with their families and friends so they could maintain important family relationships. Staff understood the different forms that people's intimate and family relationships could take and were respectful and supportive of this.

Relatives told us they that they could visit the hospice when they needed to. Visiting times were flexible so that family members could visit when it was convenient for them. We saw that staff welcomed visitors and gave them time to be with their relatives or friends. Children were able to visit the hospice and there were areas provided with toys and games for them.

Is the service responsive?

Our findings

The hospice responded to changes to people's care needs and involved people in decisions about their care. One person said, "The staff listen to you and act on what you say."

When people were referred to the hospice they received a detailed assessment of their needs. The referrals were then presented to the multidisciplinary team meetings so that professionals could decide on the best way to meet a person's needs. Staff were aware of the importance of assessing people's needs in a non-discriminatory way that promoted people's equal access to the service.

People had a choice of where they received end of life care. The hospice multidisciplinary team would assist people if they wished to spend the last days in their own homes. One person said, "I knew what I was coming into, and I think that when people hear the word hospice they think straight away 'end of life' which is not the truth." In cases where people's conditions and symptoms had stabilised enough so that they did not require any immediate end of life care, staff at the hospice would plan discharges and liaise with the external community team. The hospice was also considerate of people's changing needs and would readmit people if required.

Care records showed that people had care plans based on a comprehensive assessment of their needs. Things that people wanted to happen regarding their care and how their needs should be met were included in their care plans. One person told us, "I have been involved in my care, about my medication and what I take and about going home."

Care plans showed that people and their relatives had been involved in planning their care. Where people's needs changed care plans had been updated to reflect this. For example, when people needed changes to their medicines regimes to manage their symptoms. Care plans had been reviewed to reflect the changes.

People and relatives were able to access a number of activities at the hospice. People could access a gym and an exercise program to maintain their fitness and general health. One person told us, "Yes I go to the gym which is new to me and I really enjoy it." People and relatives could also have one to one acupuncture sessions, and group relaxation and Sound Bath activities. The hospice also provided a carers clinic, where carers could meet for mutual support.

People and relatives were able to share their views and comments about the service provided by the hospice. The hospice had received a number of compliments about how people had had a positive experience of the service. Compliments were posted on notice boards on the wards. The hospice had 'you said we did' posters which reflected feedback they had received from people and relatives and what they had done about it.

People and relatives told us that they knew how to make a complaint and that they were confident their concerns would be addressed appropriately by the hospice, if they had any they wanted to raise. One person told us, "I can't complain about anything here. If I was going to complain I would complain to the

manager." Information regarding how to make a complaint was available in the hospice on notice boards. Staff knew who people should contact if they wished to make a complaint. Records showed that where complaints had been made these had been investigated and the issues addressed appropriately.

Is the service well-led?

Our findings

People and relatives received a service that was appropriately tailored to meet their needs as there was in place a clear management structure with senior staff having clearly defined roles and responsibilities to lead the service delivery. Staff were committed to the mission and values of the hospice and knew the expected behaviours and conduct that they needed to demonstrate in carrying out their work. Through the induction process and ongoing training staff were enabled to put these values into practice in their work.

Marie Curie hospice Hampstead had a management team consisting of the registered manager, medical director and clinical lead nurse. This local management team, supported by the Marie Curie Senior leadership team, were responsible for the ongoing monitoring of and making improvements to the service. They also worked with senior leadership team to ensure that the aims and objectives of the service provider were met.

People were provided with a service that continuously sought to improve as systems were in place to monitor the quality of the service. People's views were sought regularly as the hospice had user feedback volunteers who worked on each of the wards and outpatient service seeking people's views regarding their experience of the service. In this way the provider sought to get real-time feedback on the delivery of the service. There were also comment cards and comment boxes on each of the wards and outpatient service for people to comment on the quality of the service they received. Comments cards were reviewed and action was taken by the management team to improve the service. This was then fed back to people and relatives so that they knew what had been done as a result of the suggestions they made. People told us that they had been able to and had been asked for their views of the quality of the service.

The provider had carried out annual satisfaction surveys of staff and people to get their views about the quality of the service. The last surveys had been completed in 2015. The survey had been carried out by an independent organisation. We saw that an action plan had been produced and implemented to address areas that had been identified as needing improvement. The provider was in the process of carrying out a further survey of the views of staff and people in 2016.

The hospice had quality assurance systems that covered various areas of clinical care. For example, infection control, falls and care planning. Marie Curie carried out an audit of compliance. This allowed for learning and benchmarking of the quality of service delivered by all Marie Curie hospices.

A medicines management group meeting was held quarterly and chaired by a palliative care consultant. It was attended by the pharmacist, pharmacy technician, registered manager and the clinical lead nurse. We saw evidence that medicines incidents were dealt with appropriately and practice was amended where applicable. Staff reported medicines incidents on a paper form. The information on the forms was then transferred to an electronic system. Medicines incidents were discussed on a weekly basis at an incident meeting and any learning were shared across teams as necessary, to prevent re-occurrence.

There was a robust system to deal with medicines alerts. National medicines alerts were received by the

pharmacist as well as senior head office staff. The pharmacy technician kept a log of all medicines alerts received and all actions that needed to be taken, if applicable.

Incidents, accidents and complaints were reviewed by the incident review group on a weekly basis. This group is well attended and included senior nurses, pharmacist, supportive care services manager, practice educator, the registered manager and palliative care consultant so all incidents are fully reviewed for learning to take place. Complaints had been reviewed by this group to see whether appropriate action had been taken to deal with complaints and if there were lessons to be learned. Staff understood how to handle incidents and report accidents. Records showed that these had been recorded and appropriate action taken to prevent reoccurrences of an incident and accident.

The provider took whistleblowing allegations seriously and dealt with them appropriately. Prior to the inspection we received a whistleblowing concern relating to the admission of certain patients and alleging that the hospice was admitting people whose needs could not be met. The registered manager told us that a similar whistleblowing had been received in 2014. They were able to show us a report outlining how they had responded to these concerns.

The hospice had recruited volunteers to help to deliver on its objectives and had links with local communities. Volunteers played an important role in supporting people who used the service and were involved in a range of activities. The hospice voluntary services manager had developed strong links with local communities so that volunteers reflected the diverse groups that the hospice served.

Research was being undertaken in the hospice. For example, the lead physiotherapist and occupational therapist explained that they were involved in the Goal Attainment Score (GAS) study which the hospice is an initial test site for. This is a multi-site study of the rehabilitation approach that is led by the Therapies team. GAS is being explored as an outcome measure. This had started to improve goal setting with the patients.

The hospice carried out research with partner organisations on aspects of palliative and end of life care to identify and promote best practice in this field. There were appropriate processes within Marie Curie to monitor research in relation to ethics and governance to ensure research was being carried out appropriately.