Fair Havens Community Hospice Service

Quality Report

Heath Centre,
Daws Heath Road,
Thundersley,
Essex
SS7 2LH
Tel: 01702 220350
Website: www.havenshospices.org.uk

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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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Fair Havens Community Hospice Service is operated by Havens Christian Hospice. The service provides community hospice care across Essex.

We inspected this service using our comprehensive inspection methodology. Our inspection was announced 48 hours prior to the inspection, to ensure that everyone we needed to talk to was available. The service was inspected on 29 November 2018.

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.

Services we rate

We rated this service as **Good** overall because:

- Staff kept patients safe from harm and abuse. Risks were assessed, monitored and managed appropriately.
- Staff followed best practice in relation to infection prevention and control. The maintenance and use of equipment kept people safe.
- Care and treatment records were accurate, stored securely and provided comprehensive details of care and treatment.
- Staff recognised incidents and knew how to report them. Managers investigated incidents and made improvements to the service.
- Staff had the appropriate skills, training, knowledge and experience to deliver effective care and treatment.
- Staff delivered care and treatment in line with evidence-based practice.
- Information about the outcomes of patient care and treatment was routinely collected and monitored.
- Staff involved patients and carers in decisions about their care and treatment.
- Staff cared for patients with compassion, treating them with dignity and respect.
- The service was planned based on the needs of local people, and new initiatives were set up to improve the service.
- There were clear processes for staff to manage complaints and concerns.
- There was an open and transparent culture, with engaged and experienced leadership.

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

- Learning from incidents was not consistently shared amongst staff.
- Progress was not documented on the community risk register; therefore, it was unclear which items had been reviewed and remained a risk.

Summary of findings

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Amanda Stanford
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospices for adults	Good 	The service provides palliative nursing care to adults living with a life limiting condition. All services were provided within the community. We rated this service as good because it was safe, effective, caring, responsive and well led.

Summary of findings

Contents

Good

Fair Havens Community Hospice Service

Services we looked at:
Hospices for adults

Summary of this inspection

Background to Fair Havens Community Hospice Service

Fair Havens Community Hospice Service is operated by Havens Christian Hospice. The service has been registered by the CQC since March 2017. The service provides a hospice at home service and a managed care service. The hospice at home service provides planned and crisis respite support for patients living in Castle Point, Rochford and Southend. The managed care service provides continuing health care to patients approaching the end of life, living in Castle Point and Rochford.

The service has had a registered manager in post since March 2017. A registered manager is a person who has registered with the CQC to manage the service. They have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is run.

The service is registered to provide treatment of disease, disorder or injury.

Fair Havens Community Hospice Service had not been inspected before. We inspected the service on 29 November 2018 and our inspection was announced at short notice, to ensure that everyone we needed to talk to was available.

Our inspection team

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

Information about Fair Havens Community Hospice Service

The service is registered to provide the following regulated activity:

• Treatment of disease, disorder or injury.

During our inspection, we visited the service base in Thundersley, Essex. We spoke with eight members of staff including; nurse coordinators, nursing assistants, and senior managers. We spoke with three patients and two relatives. We reviewed five sets of patient records.

There were no special reviews or ongoing investigations of the service by the CQC during the 12 months prior to inspection. This was the service's first inspection since registration with CQC.

In the reporting period September 2017 to August 2018, the service provided care to 376 patients.

Track record on safety (October 2017 to September 2018)

- No never events
- No serious incidents
- No incidences of Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff) or E-Coli
- One complaint

Fair Havens Community Hospice Service does not provide any services accredited by a national body.

There are no services provided at the hospice under service level agreements.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **Good** because:

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

However:

- Learning from incidents was not consistently shared amongst staff.
- The service did not conduct infection prevent and control (IPC) audits and therefore could not be assured that staff were complying with IPC policies and procedures.

Are services effective?

Good

We rated effective as **Good** because:

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

Are services caring?

Good

We rated caring as **Good** because:

Summary of this inspection

- Staff provided compassionate care, treating patients with dignity and respect.
- Staff understood the importance of providing emotional support to patients and those close to them.
- Staff involved patients and carers in decisions about their care and treatment.
- Staff communicated with patients about their care and treatment in a way they could understand.

Are services responsive?

Good

We rated responsive as **Good** because:

- The service was planned based on the needs of local people, and new initiatives were set up to improve the service.
- Patients could access the services they needed.
- There were clear processes for staff to manage complaints and concerns.

Are services well-led?

Good

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

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

However:

- Progress was not documented on the community risk register; therefore, it was unclear which items had been reviewed and remained a risk.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Hospices for adults

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

Are hospices for adults services safe?

Good

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

Mandatory training

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

- Staff completed 11 mandatory training modules as part of their induction and were required to update them annually. Training was delivered through a combination of online assessment and practical face-to-face training days. Mandatory training included manual handling, record keeping, infection control, cardiopulmonary resuscitation (CPR) and medicines management.
- As of December 2018, the service had an overall training compliance rate of 83%, against a target of 90%. Managers monitored training manually and would notify staff when their training was due for renewal.
- Nursing assistants who were new to the role were required to complete the national care certificate. The certificate aimed to prepare nursing assistants with the knowledge and skills to provide safe and compassionate care.

Safeguarding

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

- Staff knew what the term safeguarding meant and how to recognise signs of abuse. They could explain the reporting process and knew how to seek support from the safeguarding lead, if needed. Nursing assistants would escalate any safeguarding concerns to the nurse coordinator, who would then make the referral.
- Fair Havens Community Hospice Service provided care to adults. The intercollegiate document 'Safeguarding children – roles and competencies for healthcare staff' (2014) published by the Royal College of Paediatrics and Child Health, provides guidance on the level of safeguarding training required for different staff groups. The document states that all clinical staff who have any contact with children should be trained in safeguarding children level 2.
- The service ensured staff training and competencies reflected government guidance. As of December 2018, all staff had been trained in safeguarding adults and safeguarding children level 1 and level 2. Three members of staff, including the safeguarding lead, had been trained in safeguarding adults level 3.
- Havens Christian Hospice used volunteers to help with the day to day running of services. All volunteers supporting a regulated activity were required to complete a disclosure and barring service (DBS) check. A DBS check allows organisations to make safer recruitment decisions, by identifying candidates who may be unsuitable for certain work. At the time of our inspection, no volunteers were currently supporting the Fair Havens Community Hospice Service.
- The service had developed a 'safeguarding folder' to support staff with all aspects of safeguarding. The folder contained safeguarding definitions, guidelines and contact details, including who staff should contact out of hours if they had a safeguarding concern.

Cleanliness, infection control and hygiene

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

- Staff took steps to prevent the transmission of infections. For example, staff used effective hand hygiene techniques and their arms were 'bare below the elbow' when providing care. We saw staff washing their hands before and after contact with patients. This was in line with the National Institute for Health and Care Excellence (NICE) Quality Standard 61 (2014), which states that staff should decontaminate their hands immediately before, and after, every episode of direct contact care. From October 2017 to September 2018, the service reported no healthcare acquired infections.
- The service had an up-to-date infection prevention and control (IPC) policy, which set out the process for the management, collection and surveillance of infection control data. Staff used appropriate protective equipment, such as gloves and aprons, when providing personal care.
- The service offered 'last offices' to all patients. Last offices describes the procedures performed to the body of a deceased person, shortly after death has been confirmed. Following a patient's death, staff would alert the funeral directors to any transmissible diseases and ensure wounds were clean and covered.
- Although we were told that the service used team meetings to monitor staff techniques in hand washing, the service did not conduct IPC audits. The service therefore could not be assured that staff were complying with IPC policies and procedures.

Equipment

The maintenance and use of equipment kept people safe.

- The environment was not inspected as part of this inspection. Staff were based at the Heath Centre and provided care from within patient's homes.
- Staff told us they had enough equipment to deliver safe care and were able to order equipment when needed. Equipment was ordered through various routes, depending on the equipment type. Staff could directly order patient beds and commodes through social care provision, or via the community healthcare team. The local NHS community trust could order pressure relieving equipment, if required by the patient. Physiotherapy equipment, such as walking aids, were available to order from the physiotherapist employed by Havens Christian Hospice.
- A syringe driver is a small infusion pump, used to gradually administer small amounts of fluid medication under the patient's skin. They were sourced and maintained by the local community NHS trust. All community staff were required to complete syringe driver training to ensure its safe use.
- The service provided all patients with a care box containing various consumables, such as disinfection wipes, gloves and slide sheets. The care boxes ensured both staff and carers had the equipment they needed to deliver safe care.
- Staff complied with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The managed care service provided all patients with a sharps bin, to be used for the safe disposal of needles and syringes. All sharp bins were returned to the Heath Centre for disposal. The local NHS community trust provided sharp bins to patients using the hospice at home service.

Assessing and responding to patient risk

Staff assessed, monitored and managed patient risk.

- The service used a holistic patient assessment tool, adapted from the Gold Standards Framework (2009). The tool covers all the domains of an assessment through the acronym PEPSI-COLA (physical, emotional, personal, social support, information and communication, control and autonomy, out of hours, living with your illness, and aftercare). The tool was used by staff as an aide-memoire to guide holistic discussions with patients and their families. Nurse coordinators confirmed they used the PEPSI-COLA as part of their care assessment and the records we reviewed supported this. Nurse coordinators developed a personalised care plan to reflect the PEPSI-COLA assessment, for the nursing assistants to follow.
- Alongside the PEPSI-COLA assessment, staff completed risk assessments for all patients. Risk assessments included assessing the risk of moving and handling, pain, nausea, and pressure ulcers. We reviewed five sets of patient records and found that all contained detailed risk assessments. Staff acted to reduce any identified

risk to patients. For example, for patients at risk of falling, staff provided walking aids, to assist with their movements and installed bed rails (as appropriate) to prevent the patient from falling out of bed.

- Nursing assistants escalated any patient concerns to the nursing coordinators. Nurse coordinators reviewed patients regularly and updated their risk assessments when needed. If a patient deteriorated or was in pain, staff would seek medical support or contact the local NHS community trust. If a patient rapidly deteriorated and a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) was not in place, the emergency services would be the first point of contact. Staff had been trained to enable them to perform cardiopulmonary resuscitation, while awaiting the ambulance's arrival.

Staffing

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

- The service was delivered by a sister (band 8), five nurse coordinators (registered nurses at band 6), 20 nursing assistants (band 2) and administrative support. The service was led by the head of community services and supported by the director of care. As of November 2018, the community service had no vacancies.
- Staffing levels and skill mix were reviewed to ensure patients received a safe service. Each shift was led by a nurse coordinator and supported by a team of six nursing assistants. The service delivered care to a maximum of 12 patients per day. At night, two nursing assistants provided an overnight respite service in the patient's home.
- The service did not use bank or agency staff to cover qualified nursing staff or nursing assistants. Unexpected staff shortages were covered by the service's own staff. From April 2018 to October 2018, the service reported an overall sickness rate of 4.1%, against a target of 3.9%.
- Although the service was nurse-led, staff had access to appropriate medical input when needed. Staff were supported by a consultant employed by Havens Christian Hospice. Staff could also contact the patient's GP for medical advice. Out of hours, staff could contact a consultant working for the local NHS community trust.

Records

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

- Staff followed a records management policy and procedure, which set out staff responsibilities in the preservation, retention and destruction of records. It also detailed standards of confidentiality and rights to access records.
- Patient records were stored on an electronic patient record. The system was password protected and accessible to all staff working in the service. Staff told us the system was user-friendly and that it was easy to find information. Nurse coordinators were provided with laptops to enable them to work remotely.
- The provider used the same system as the local GPs, the local NHS community trust and the local NHS acute palliative care team, which ensured patient information was shared between organisations in a timely manner.
- For some information, staff also used a paper record, held by the patient. The paper record included risk assessments, consent documentation and information for patients and their families to complete.
- As part of our inspection, we reviewed five sets of patient records. All were clear, concise and accurate, focusing on the needs of the patient. Within the records we saw evidence of good communication and multidisciplinary team (MDT) working. Risk assessments had been completed and highlighted potential risks to patient safety.
- Records were audited regularly to identify areas for improvement. Results from an audit completed in September 2018 identified themes for improvement. For example, the arrival time was not consistently documented in the patient's record. From the findings, an action plan was created and a re-audit scheduled for January 2019.

Medicines

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

- Fair Havens Community Hospice Service did not stock any medication.
- Medicines were mainly prescribed by GPs or by the local NHS community trust. Nurse coordinators and nursing assistants administered the prescribed medicines using the medicine administration record (MAR). We reviewed three MAR charts and found allergies were clearly

documented. All staff were required to complete medication and MAR training before administering medicines. As of December 2018, 100% of staff had completed the training. Trained and competent nursing assistants would always administer a medicine with another colleague, to reduce the risk of a medication error, in line with the National Institute for Health and Care Excellence (NICE) Guideline 67 (2017).

- The service worked in collaboration with the local NHS community trust to support the day-to-day management of syringe drivers. The syringe drivers used complied with all required National Patient Safety Agency (NPSA) standards. Only staff trained in the use of syringe drivers were able to manage them. As of December 2018, 70% of staff had completed the syringe driver training. Staff knew who to contact in the event that there was a problem with the syringe driver.
- Two of the nurses in the team had completed additional training to enable them to prescribe certain medicines. Non-medical prescribers were required to complete a competency framework developed by the Royal Pharmaceutical Society on a yearly basis.
- Anticipatory prescribing is designed to ensure a patient always has access to medicines to manage common symptoms that can occur at the end of life. Non-medical prescribers were able to prescribe anticipatory medications when needed.
- Arrangements were in place to ensure that medicine errors were reported, recorded and investigated. Team minutes from January 2018 showed that medicine errors were discussed and mitigations were actioned. We saw evidence that the service had learnt from medicine errors. For example, the MAR charts had recently been redeveloped to be clearer and easier to use.

Incidents

There were effective processes to report, record and learn from incidents.

- Incidents were reported using an electronic recording system. Staff we spoke with knew how to report incidents and could give examples of the recent incidents they had reported. Although the majority of staff were aware of the types of incidents they needed to escalate, we found that some staff had a limited understanding of their responsibility to record minor incidents and near misses.
- From October 2017 to September 2018, the service reported no never events. Never events are a type of serious incident that is wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Within the same time period, the service reported no serious incidents. Serious incidents are adverse events, where the consequences are so significant or the potential for learning is so great, that a heightened level of response is justified.
- No incidents reported required the duty of candour to be activated. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff were aware of the principles of duty of candour and could give examples of when it would be triggered.
- The community sister and head of community services reviewed all incidents reported to determine the cause of the incident, and to ensure steps were taken to reduce the risk of reoccurrence. Lessons learnt were recorded on the incident reporting database. In the event of a serious incident, the head of community services led the investigation.
- Although we saw evidence that the service took action following an incident, during our inspection, the staff we spoke with were unable to give examples of feedback or learning following an incident.

Are hospices for adults services effective?

(for example, treatment is effective)

Good

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

Evidence-based care and treatment

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

- Staff had access to policies and guidance in paper format and online. The 10 policies we saw were version

controlled, ratified and included clear dates for review. For example, we reviewed the safeguarding policy, and found it was ratified, in date for review and referenced national guidance such as the intercollegiate document 'Safeguarding children – roles and competencies for healthcare staff' (2014).

- The director of care and head of community services were responsible for updating new policies, in line with national guidance. Any new policy changes would be shared with the team. Staff had access to academic journals to help keep updated with new practice and guidance.
- Following the withdrawal of the Liverpool End of Life Care Pathway in 2014, the Leadership Alliance for the Care of Dying People developed an approach, intended as the basis of care for everyone in the last few days and hours of life. The approach focused on achieving five priorities for care, supporting the primary principle that individual care must be provided according to the needs and wishes of the dying person. Fair Havens Community Hospice Service delivered the five priorities for care of the dying person, ensuring patients, and those identified as important to them, are involved in decisions about their treatment and care. The service used a patient assessment tool, adapted from the Gold Standards Framework (2009), to develop clear, personalised care plans. The tool supported a holistic assessment, to ensure patient's emotional, spiritual and social needs were identified, assessed and met.
- The service had developed guidelines to support staff develop an individualised plan of care for patients. The service was also developing an end of life care pathway for staff to follow within the community.
- The service was a member of the National Association for Hospice at Home. The association works with members to develop hospice at home services and share best practice in end of life care.

Nutrition and hydration

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

- Staff used a recognised nutritional assessment tool, to assess the nutrition and hydration needs of patients approaching the end of life. We reviewed five sets of patient records and found them all to contain completed nutrition risk assessments.
- We observed staff asking patients about their nutrition and hydration needs, and encouraging families and carers to support patients with eating and drinking.
- Staff educated patients, and those close to them, about the importance of nutrition and hydration at the end of life. Staff described the importance of ensuring patients maintained good oral hygiene and mouth care. Staff could refer patients to a community dietician for support with their nutritional and hydration needs.

Pain relief

Staff assessed and managed patient pain well.

- Patients told us their pain was well managed and that nursing staff administered pain relief in a timely manner. Some patients had syringe drivers to help control their pain, which delivered a steady flow of medication.
- Patient records included an appropriate pain assessment and management plan. Pain levels were reviewed regularly to ensure each patient's pain was controlled effectively. Any pain concerns would be escalated to the patient's GP. The electronic patient records included a pain assessment for patients who were non-verbal. For patients with motor neurone disease, staff had access to specific communication aids designed by the Motor Neurone Disease Association. The communication aids included prompts to support a pain assessment.

Patient outcomes

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

- Service leads updated key performance indicators monthly onto a quality dashboard. Quality performance data was then presented at the care governance meeting for review. The quality dashboard included specific end of life care outcomes, such as whether a patient died in their preferred place of care. From April 2018 to October 2018, this standard was achieved for 91% of patients.
- At the time of our inspection, the service was not collecting data related to pressure ulcers. The director of care described plans to begin auditing additional data, such as pressure ulcers, in 2019.
- The Outcome Assessment and Complexity Collaborative (OACC) project provided specialist palliative care

services with outcome measures that could be used in palliative care. The service used the OACC outcome measure 'phase of illness' (describes the distinct stage in the patient's illness) as an indicator of quality.
- A local audit programme was used to measure quality and drive improvements to the service. For example, following an audit of the medication administration record (MAR) charts, the service identified a number of medication errors. The charts were redesigned and nursing assistants received additional MAR training. A re-audit of the MAR charts was scheduled for December 2018 to see if improvements had been made.
- In addition to local audit, the service had recently registered with the Hospice UK Safety Matrix. This would allow the provider to benchmark and compare their performance with other services nationally.

Competent staff

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

- New staff were required to attend a corporate induction and complete a local induction programme. As part of the induction, community staff spent a day working at the provider's inpatient unit and day hospice service. All new staff received a clinical competency assessment booklet and were allocated a mentor. All competencies required sign off by the mentor.
- A nursing assistant had created a nursing assistant booklet, which acted as an aide memoire to staff in the community. It contained a range of information to support nursing assistants provide care, such as pressure ulcer management, oral hygiene and blood results.
- The service had arrangements for staff supervision and appraisal. Staff identified their learning needs and development opportunities through their yearly appraisal. From October 2017 to September 2018, all nursing assistants had received an appraisal. Within the same time period, three nurse coordinators had received an appraisal. The remaining two nurse coordinators had their appraisal date booked. Nursing staff told us they were supported with their revalidation through clinical supervision. Revalidation is the process where nurses renew their registration with their professional body; the Nursing and Midwifery Council.
- The service provided staff with the training to deliver effective care, support and treatment to patients. Additional training opportunities were publicised at team meetings and on staff notice boards. Staff told us they were supported to pursue additional training opportunities, relevant to their role. For example, two members of the team had attended a pancreatic cancer day.
- Staff also delivered training to the local community. For example, following an incident transferring a patient, staff were planning a palliative care training day for local ambulance services.

Multidisciplinary working

There was effective multidisciplinary working across the service.

- Staff had strong working links with staff from external services and agencies. For example, nurse coordinators and local social workers would make joint patient visits when patient needs were complex. Staff reported good rapport and liaison with the local community palliative care team, the local acute palliative care team and district nurses.
- The service attended weekly multidisciplinary team (MDT) meetings, ran by the local NHS acute trust. They were attended by both the acute and community palliative care teams, ensuring continuity of care for patients and their families. The meetings were chaired by a palliative care consultant and attended by various members of staff, including medical staff, nursing staff, social workers and occupational therapists.
- At the MDT meetings, the patient's wishes were discussed, including their preferred place of care following discharge from the hospital. Staff described clear processes for the transfer of care from hospital to hospice at home.
- Staff could make referrals to various professionals within the community, including physiotherapists, occupational therapists and tissue viability nurses.

Health promotion

The service supported people to manage their health needs.

- Staff worked hard to help patients maintain their independence and manage their own health, to improve their experiences. Patients were signposted to various services to promote their health and wellbeing in the last months of their lives.

Good

Hospices for adults

- The service identified people who needed extra support. The service had recently started to use the Gold Standards Framework prognostic indicator tool to monitor and record changes in a patient's prognosis. The tool aimed to help healthcare professionals identify when patients needed additional support as early as possible. The tool was being used in collaboration with the local NHS acute and community trusts.
- The service supported families and carers to maintain their own health and wellbeing. Staff could signpost families and carers to the provider's support group for carers or make a referral to Macmillan carers support.
- The service provided complimentary therapies to help patients cope with symptoms, aid relaxation, and reduce tension and anxiety. Complimentary therapies covered a wide range of practices and was used alongside conventional treatments. All staff were trained to provide hand and foot massage to promote relaxation and wellbeing. Some staff were also trained in hair and beauty, and could provide patients with hair-cuts and manicures.

Consent and Mental Capacity Act

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

- The Mental Capacity Act (2005) is designed to protect patients who may lack capacity, to make certain decisions about their care and treatment. Information about the Mental Capacity Act (2005) was covered as part of staff mandatory training. Nursing assistants also had information about the Mental Capacity Act in their information booklets.
- Staff we spoke with could describe the process of assessing patient capacity. If there were concerns around a patient's capacity to make decisions, nurse coordinators would complete a mental capacity assessment and contact the patient's GP. During our inspection, we saw one capacity assessment and this had been appropriately completed to a good standard.
- Staff were aware of their responsibilities to seek patient consent, in line with current legislation. This included when verbal consent was acceptable and when written confirmation was needed. We observed staff obtaining consent from patients before delivering care.
- Patient-held records contained consent forms, which were completed when delivering complimentary therapy. We saw patient records contained consent forms and if appropriate, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. All DNACPR forms were fully completed, in date and appropriately signed.

Are hospices for adults services caring?

Good

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

Compassionate care

Staff provided compassionate care, treating patients with dignity and respect.

- We observed all staff to be courteous, professional and kind when interacting with patients. We observed staff greet patients appropriately, and introduce themselves by name. Staff obtained consent before carrying out any care or treatment.
- Patient feedback was consistently positive. Comments from thank you cards showed that patients and carers felt they had been treated with compassion. The patients we spoke with told us that staff were caring and kind. They also said that staff responded in a compassionate and timely way when they experienced discomfort or distress.
- Patients could provide formal feedback on the service through a patient questionnaire. From June 2017 to May 2018, 99% of patients who responded to the patient questionnaire felt they had been treated with dignity and respect.
- The service ensured that care after death included honouring the spiritual and cultural wishes of the patient, and their family and carers, whilst making sure legal obligations were met. The service also ensured the privacy and dignity of the deceased person was maintained, while preparing the deceased person for transfer to the undertakers.
- Staff could give examples of when the service had demonstrated a particularly caring approach to patients approaching the end of life. For example, staff had supported a patient so that they could attend their son's wedding.

Emotional support

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

Good

Hospices for adults

- We observed, and staff gave examples of, when they had provided reassurance to distressed patients and carers. Staff could access training on bereavement, to help support families and carers with their loss.
- The service offered families and carers bereavement support, either individually or as part of a group. Staff also provided information to bereaved families on how to access additional emotional, psychological and bereavement support.
- Staff supported patients to make a memory box. Memory boxes contained special items belonging to a patient, reminding family and friends of the patient and providing some comfort after the patient had died.
- Staff understood and respected the spiritual and religious needs of patients. Havens Christian Hospice held a 'light up a light' event each December. The event allowed family members and carers to dedicate a light in memory of a patient who had passed away.
- A family support team, made up of counsellors, social workers, a benefits adviser and trained volunteers, was available to provide emotional and practical support to people who came into contact with the community nursing services.

Understanding and involvement of patients and those close to them

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

- Staff provided patients with relevant information, both verbally and in writing, so they could make informed decisions about their care and treatment. Leaflets describing the process of Last Offices were supplied by the local NHS community trust. Staff ensured patients and families could find further information and support, if needed.
- Staff across the service clearly placed patients at the centre of their work. Staff added the patient's wishes into their patient record to ensure their voice was heard.
- Relatives and carers were treated as important partners in the delivery of care. Staff told us how they supported carers and relatives to provide care, to help prepare them for supporting patients alone. The service had also introduced a section in the patient held record for communication and informal feedback between the patient, family and staff.
- Staff could access additional training on communication, to ensure sensitive information was communicated effectively to patients and those close to them. As of December 2018, 13 members of staff had completed communication training.

Are hospices for adults services responsive to people's needs?

(for example, to feedback?)

Good

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

Service delivery to meet the needs of local people

The service planned and delivered services to meet the needs and demands of local people.

- The service provided a hospice at home service and a managed care service. The hospice at home service provided telephone support and a visiting service, as well as planned and crisis respite support for patients living in Castle Point, Rochford and Southend. The managed care service provided continuing health care to patients approaching the end of life, living in Castle Point and Rochford. Each service had its own admission criteria to ensure patients were only accepted if staff could meet their individual needs.
- Service leads worked with the local clinical commissioning groups (CCGs) and other healthcare providers to improve patient services. The head of community services attended the South-East Essex locality group which, together with representatives from the local council and CCGs, shaped and developed local palliative care services.
- The service worked collaboratively to identify gaps in provision in the local area. For example, the service had recently been contacted by a local ambulance service to support the transfer of a patient with non-invasive ventilation and percutaneous endoscopic gastrostomy (PEG) feeding tubes (tubes which provide food, fluids and medicines directly into the stomach). Following this, the service was planning to hold an ambulance conference to deliver end of life care training to local

ambulance services. The service had also carried out a study, in collaboration with a local NHS trust, to determine the local community need for overnight palliative care support.
- In addition, the service was currently piloting a hospice neighbours project. The service was planned to be community-based and volunteer-led, providing practical support and companionship to patients and their families. This, in turn, would allow staff to provide more specific end of life care to more patients.

Meeting people's individual needs

Staff planned and delivered services to meet individual needs.

- Staff monitored and reviewed the changing needs of patients and ensured their needs were documented in their care plan. All patients were provided with an IAM form, which supported staff to deliver patient-centred care. It provided an easy and practical way of recording information about the patient. The document was designed to be completed by the patient and their family, allowing staff to identify and meet individual needs. However, of the three IAM forms we reviewed, none had been completed by the patient or their family.
- The service identified and met the communication needs of patients. All communication needs were documented in the patient records. Staff told us they had access to interpreting services for patients who did not speak English. For patients who were unable to speak, the service ensured other methods of communication were put in place. For example, for patients with motor neurone disease, staff had been trained to use a piece of equipment to interpret eye gaze movements.
- The service provided all patients with a care box containing various consumables, such as disinfection wipes, gloves and slide sheets. The boxes were particularly useful for patients without family or the means to purchase essential care items. The boxes ensured staff had essential equipment to deliver care to patients, regardless of their situation.
- The service identified and met the spiritual and religious needs of patients and those close to them. A chaplaincy service was available 24 hours a day, seven days a week, offering emotional support. The service had access to faith leaders from various faiths, if needed.

Access and flow

Patients could access the services they needed.

- Patients accessed the service in a variety of ways. Most referrals came from the patient's GP, community nursing teams or the local NHS acute trust. Referrals were passed on to either the community sister, or one of the nurse coordinators, to complete an assessment and determine the level of care required.
- The managed care service provided continuing health care to patients approaching the end of their life. Following a referral, staff reviewed the patient within two days, or for fast-track patients, the patient would be reviewed on the same-day. From April 2018 to October 2018, this standard was achieved 100% of the time. Patients were reassessed within two weeks of care and were transferred back to community health care if their condition remained stable. The managed care service provided care 24 hours a day, seven days a week.
- The hospice at home service provided telephone support and a visiting service, as well as planned and crisis respite support for patients and their families. The telephone service was available 24 hours a day, seven days a week and the visiting service was available between 7am and 10pm. Staff provided day respite care from 8am to 10pm, and night respite care from 10pm to 7am. Overnight respite care was prioritised for patients who were within the last days of life or for carers who required further support. From September 2017 to August 2018, the service received 284 requests for respite care.
- Following a referral, the hospice at home service contacted patients within two days, or more urgently if the request was for respite crisis. From April 2018 to October 2018, this standard was met 99% of the time.
- Staff ensured families understood the practical arrangements needed after the death of their family member. A nurse coordinator had completed verification of expected death training which meant families did not have to wait for a GP to verify a patient death.

Learning from complaints and concerns

There were clear processes for staff to manage complaints and concerns.

- Staff followed an up-to-date complaints policy, which provided guidance on how to manage complaints

efficiently. Staff also completed online conflict resolution training, with the aim to resolve conflict safely, efficiently and with minimal distress to those involved.

- Staff recorded all complaints and concerns in a complaints log. The log was developed to ensure staff learnt from complaints and improved the service. Complaints were shared and discussed at trustee board meetings and at team meetings.
- The head of community services and the community sister led on the investigation of all complaints. Complaints were required to be acknowledged and investigated within five working days, or 20 days for more complex complaints.
- Complaints leaflets, describing the complaints procedure, were provided to all patients. From September 2017 to August 2018, the service received one complaint. The complaint related to a miscommunication between a member of staff and a family relative. Within the same reporting period, the service received 26 compliments. Within the compliments, specific thanks were given to the night staff providing respite, highlighting the value of the overnight service to families and carers.

Are hospices for adults services well-led?

Good

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

Leadership

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

- Fair Havens Community Hospice Service had clear lines of management responsibility and accountability. The service was overseen by a board of trustees, led by the chair. The senior leadership team included a chief executive and five directors. Nursing leadership was provided by a director of care, head of community services and community sister.
- The nursing team was managed by visible and experienced leaders. They were knowledgeable about the hospice and aimed to continuously improve their service. For example, the head of community services was leading the development of a hospice neighbour service to improve patient support.
- All staff spoke positively about their local leadership. They described feeling valued and supported in their role. Staff who worked remotely said they felt connected to the team and to the organisation.
- Community leads felt supported by the senior leadership team. The senior leadership team were visible and were invited to attend team meetings. Following feedback in the staff questionnaire, the senior team had also started 'Haven huddles' to improve their visibility. The huddles ran monthly and allowed staff to ask directors questions and discuss service developments.
- The senior leadership team understood the challenges to quality and sustainability, and could identify the various actions needed to address them. For example, the service regularly met with the local clinical commissioning groups to review service provision against demand. Community leads had good oversight of activity, performance, staffing and safety in their service.

Vision and strategy

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

- The provider had an overarching mission, which fed into the vision and strategy for the service. The mission was: 'making every day count'. The provider planned to achieve this by focusing on the individual needs of patients and their families.
- The senior leadership team had a vision for what it wanted to achieve within the community service, and had started to action their plans. For example, the service had recently recruited into the managed care service, enabling the service to increase its caseload.
- Plans to expand the service to meet patient need were developed with support from the local commissioning groups. Staff we spoke with were fully informed of the plans to develop the service, and their role in achieving them.

Culture

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

- Staff reported an open and honest culture. Staff felt able to raise concerns with their manager and we observed

leaders had an open-door policy. The service had appointed a 'freedom to speak up guardian'. Guardians promoted an open culture, allowing staff to speak up about concerns easily.

- There were positive working relationships and cohesive team work across the service. There was a clear culture of multidisciplinary learning to improve patient care.
- There were opportunities for further learning and development. Staff told us that they were encouraged to go on courses that enabled them to develop personally and professionally.
- The service took measures to protect staff working in the community. For example, all visits were risk assessed and most visits were undertaken by two members of staff. Staff followed a lone working policy and reported to the nurse on call when they arrived and left a patient's home. The service was also planning to provide personal alarms to all staff working in the community.
- The service recognised the emotional impact of caring for patients at the end of their life. The provider ran a monthly wellbeing therapy service for staff. Staff support was also available from the provider's counsellor. Staff debrief support sessions were held following a particularly distressing patient death.

Governance, risk management and quality management

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Staff were clear about their roles and understood what they were accountable for. Staff demonstrated a good awareness of governance arrangements and knew how to escalate concerns.
- Information was shared through regular team meetings. These meetings reported into the clinical quality meetings which, in turn, reported into the care governance meeting. The meeting minutes we reviewed from December 2017 to June 2018 showed that risks were routinely reviewed by staff at all levels.
- The service had an electronic risk register, managed by the head of community services. Each risk was given a rating, responsible individual and mitigation response. Risks included lone working and remote access to the electronic patient records system. Risk progress was not documented on the risk register; therefore, it was unclear which risks had been reviewed and remained a risk.
- The service collected performance data through quality dashboards. The dashboards provided the senior leadership team and the board of trustees with an overview of how the service was performing. The dashboards included key quality indicators such as the number of incidents and complaints, staffing levels and waiting times.
- There was also a programme of clinical audit across the service, which meant senior staff could monitor compliance with safety standards. Where audits had been carried out, there was evidence that service leads had used the results to implement improvements and changes to the service.

Engagement

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

- The hospice worked in partnership with other services providing end of life care to ensure they effectively met patient needs, such as GPs and the local NHS community trust.
- Families and carers could provide feedback on both the managed care service and hospice at home service using the patient questionnaire. From April 2017 to March 2018, 97% of people who completed the questionnaire rated the service as either 'excellent' or 'good'. The remaining 3% did not respond.
- Staff were engaged in the planning and delivery of the service. Staff attended regular team meetings to share ideas, opinions and feedback their concerns. We reviewed meeting minutes from June 2018 and saw that patient feedback was also discussed.
- In addition, staff completed an annual staff survey. The most recent staff survey identified concerns with communication from the senior leadership team. From this, 'Havens huddles' was introduced to improve both leadership communication and visibility. We found the huddles had been positively received by staff.
- Staff ideas were reviewed and implemented, in order to improve the service. For example, a nursing assistant had created an information booklet to support nursing assistants provide care in the community.

Good

Hospices for adults

Learning, continuous improvement and innovation

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

- The service was looking to procure transport vehicles. The service could then transport patients to their chosen place of death without delay.
- The service was currently piloting a hospice neighbours project. The project would be community-based and volunteer-led, providing practical support and companionship to patients and their families. This, in turn, would allow nursing staff to provide end of life care to more patients.
- The service wanted to develop the clinical role of registered nurses for patients at home. The role would include phlebotomy (the act of removing blood for testing, using a needle) and cannulation (the act of inserting a thin tube into a vein to administer medication, drain off fluid, or insert a surgical instrument).

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve
The provider should ensure learning from incidents is consistently shared amongst staff.

The provider should ensure that risks are regularly reviewed and that this process is documented on the risk register.