Harlington Hospice Association Limited

Michael Sobell Hospice

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

This was the first time we rated this service. We rated it as requires improvement because:

- Patient records were not stored securely.
- The service did not ensure all staff completed their mandatory training.
- The service did not always control infection risks well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. They did not always keep equipment and the premises visibly clean.
- Staff did not always keep patient safe by ensuring infection prevention and control and cleaning measures were sufficient, in place and adhered to. Staff did not ensure the safe storage of controlled substances which may be hazardous to health.
- Staff did not monitor patients regularly to see if they were in pain and therefore may not always give pain relief in a timely way.
- Leaders did not always operate effective governance processes throughout the service.
- Leaders did not run services well using reliable information systems.
- Leaders and their teams did not always identify and escalate relevant risks and issues or identify actions to reduce their impact.

However:

- The service had enough staff to care for patients.
- Staff provided patients with enough to eat and drink.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, and had access to good information.
- Staff were enthusiastic about working at the service and said they had visible leaders.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
End of life care	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to Michael Sobell Hospice

Michael Sobell Hospice is operated by Harlington Hospice Association Limited and opened in 2020. Michael Sobell Hospice is an independent hospice in the London borough of Hillingdon. They primarily serve the community of Hillingdon but does provide care for patients from the surrounding areas of Harrow and Hertfordshire.

The hospice is situated in a building in the grounds of an NHS hospital. The building is fully accessible and has facilities for inpatient care, therapies and family support. The hospice provides adult hospice services that provide palliative care, family support services for adults, children and young people and a night-time home service for palliative and end of life patients. The hospice has 10 inpatient beds. We inspected the service using our comprehensive inspection methodology. We carried out an unannounced inspection on 4 July 2022. During the inspection, we visited the hospice's inpatient unit and we spoke with staff from the hospice at home team as well as patients and family members.

How we carried out this inspection

Our inspection took place on 4 July 2022 with staff and patient interviews taking place by telephone and video conference on 5 and 6 July 2022, using our comprehensive inspection methodology. The inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We observed care and treatment and looked at three sets of patient notes. We spoke to four patients and their families, ten members of clinical and non-clinical staff. We observed care and treatment provided in the inpatient unit and reviewed other information and data provided by the hospice to make our judgement.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- Ensure that all mandatory training levels meet the service's target, and all staff complete their mandatory training. **Regulation 12(2)(c)**
- Ensure that clinical audits are undertaken **Regulation 17(2)(f).**
- Ensure all policies are within their review date and they contain the latest up to date national and best practice guidance. **Regulation 17(2)(a)**
- Ensure effective stock control and rotation systems are in place to manage the use by dates of consumables. **Regulation 17(2)(b)**
- Undertake records of patients' care and treatment and ensure that these are individualised and specific to each patient's needs. **Regulation 17(2)(c)**
- Ensure that service user records are stored securely. **Regulation 17(2)(c)**

Summary of this inspection

- Risk register must include all risks with dates, risk scoring and evidence of owner ship of the risk. **Regulation 17(2)(b)**
- Collect and present data in a format that manager and staff can understand and use to inform decision making. **Regulation 17(2)(a)**
- Ensure the service is clean, that infection prevention and control measures are in place and being used effectively and that cleaning chemicals are stored appropriately and safely. **Regulation 17(2)(b)**

Action the service SHOULD take to improve:

- Ensure that service user's pain is assessed using pain assessment tools.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
End of life care	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

End of life care

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

Are End of life care safe?

Requires Improvement

TThis was the first time we rated safe. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff.

The mandatory training was comprehensive and met the needs of patients and staff. The service had 24 modules listed as part of their clinical mandatory training with a further two modules for non-clinical staff. All staff we spoke with told us they felt supported with their training.

Managers monitored mandatory training and alerted staff when they needed to update their training. They monitored non-compliance and took action to address shortfalls in completion, we saw regular monitoring of staff training at board committee meetings. The initial evidence provided by the service demonstrated they were not meeting their target of 85% staff completion of mandatory training for 16 out of 26 mandatory training modules. However the service provided further data after the inspection, as the provider identified that the original data submitted had not been quality assured. This showed that the mandatory training completion target of 85% had been achieved for all but five of the 26 modules.

Mandatory training compliance reports were shared at senior leadership meetings as part of the hospice's governance processes. The service had recognised this risk and had added it to their risk register. They reported progress in addressing the risk at bi-monthly quality and governance subcommittee meetings.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The service had a safeguarding policy that was in date and ratified by the trustees. The policy was in accordance with published inter-collegiate guidance on adult safeguarding. Staff we spoke with knew how to access the safeguarding policy.

All staff and volunteers had completed a Disclosure and Barring Service (DBS) check, that was at the correct level for their role, which was repeated as required.

Requires Improvement

End of life care

Staff received specific training relevant to their role on how to recognise and report abuse. Staff we spoke with confirmed they had received safeguarding training and training figures confirmed this. The service was unable to provide accurate, quality assured data at the time of the inspection. Following the inspection the service provided further data which had been quality assured and showed that the service had met its target for 85% completion of training for all safeguarding training, adults and children levels.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. There were processes on how to escalate concerns that included contact details for raising alerts with external authorities.

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff demonstrated an understanding of safeguarding processes and gave examples of when these had been implemented.

Cleanliness, infection control and hygiene

The patient care areas of the premises were not all visibly clean. Staff used infection control measures when transporting patients after death. The patient care areas of the premises were not all visibly clean.

Patient areas including the patient bays, hub area, sluice room and cleaning cupboard were dusty. There were patches of dirt on the floor and collections of dust in corners and along the edges of walls. The communal and reception areas were visibly clean. The patient area, communal and reception areas all had suitable furniture which was visibly clean.

The cleaning cupboard was untidy and visibly dirty but lockable. However, control of substances hazardous to health (COSHH) products were not stored in a locked cupboard. We found a number of COSHH products stored inappropriately in the sluice room, one of which had been decanted into another container with a handwritten label which did not display all the hazards.

In the sluice room under the sink we noted that two bottles of cleaning solution had dust on them which indicated they had been there for a long period of time and cleaning had not been undertaken.

Cleaning records were not consistently completed. We did not see evidence that all areas were cleaned regularly. Regular cleaning audits were not undertaken.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. However, we found one “I am clean” sticker which was dated 5 July 2022 which was the date after the inspection. The cleaned equipment was on a trolley in the sluice room which was dusty.

Hand washing posters were displayed around the hospice. Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff adhering to being bare below the elbow. We saw evidence that hand hygiene audits were undertaken by the service monthly. The scores ranged from 94% to 100% compliance.

Environment and equipment

The design, maintenance and use of facilities, kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, the premises and equipment were not always visibly clean.

The service had enough suitable equipment to help them to safely care for patients. All equipment had been suitably maintained and electrical safety testing had been completed.

Requires Improvement

End of life care

During our inspection we found 154 items of out of date consumables. These included sterile gloves, sterile lubrication gel, urine collection bags and dressing packs. The oldest expiry date was March 2020. Using out of date consumables may reduce their effectiveness or they may no longer be sterile and could place patients at risk of infection.

All facilities were on the ground level with restricted access gained via a buzzer system. The layout of the service meant that it was suitable for people with accessibility needs meeting national guidance, all patient rooms had access to the garden area. The service had four side rooms with en-suite bathrooms and two bay areas which were airy and spacious. There were two wet rooms and a patient bathroom.

The environment facilitated staff to care for the deceased and their families that promoted dignity and respect. Care for these patients and their families was managed in an individual room. The patient could stay in the room with their family following their death as the service used a cold mattress to keep the deceased cool until the third-party undertaker arrived.

Call bells were in reach of patients during our inspection.

Staff disposed of clinical waste safely. We saw that clinical waste was separated correctly and that the correct colour coded bags were used for waste management. The service undertook quarterly waste audits.

Staff carried out daily safety checks of specialist equipment. Regular checks of the resuscitation equipment used in the event of an emergency were undertaken and documentation consistently completed.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and so remove or minimise risks.

Staff did not routinely complete risk assessments for each patient on their admission, using a recognised tool, and did not always review this regularly, including after any incident. Staff had access to a range of risk assessment tools including assessments for pressure ulcer, pain, bed rails, falls and malnutrition to identify specific risks. When these were completed a care plan was developed to mitigate the identified risks. During a review of three sets of patient records we found assessments were either not completed or partially completed by staff. For example, in two sets of patient records, we found skin bundle assessments had not been completed despite one of these patients having been admitted with a pressure ulcer. In another record, a malnutrition universal screening tool (MUST) had been partially completed.

Shift changes and handovers included all necessary key information to keep patients safe for example, updates on patient's wellbeing over the day or night, changes to medications and anything else that might be significant. Staff told us they had enough time to share information during shift changeovers. Information shared included the patient's physical, emotional and social needs. Nursing staff and doctors reported good working relationships and felt well supported and part of a team. The hospice at home team and inpatient unit staff reported good working relationships between the two areas and could seek support from each other when needed.

Nurse staffing

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

Requires Improvement

End of life care

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. Staffing levels were planned and reviewed so that there were enough staff in relation to the number of patients on the unit.

The managers could adjust staffing levels daily according to the needs of patients, they used bank staff when required. On the day of our inspection the number of nurses and healthcare assistants matched the planned numbers. Acuity and dependency tools were in use on the inpatient unit to monitor patient dependency and ensure that the planned and actual staffing numbers reflected need.

The service had low rates of vacancies, staff turnover and sickness. At the time of our inspection the inpatient unit had 1.2 whole time equivalent (WTE) registered nurse vacancies and the hospice at home service had one WTE vacancy for a co-ordinator and two WTE vacancies for registered nurses. These posts were being actively recruited to.

The service had low rates of usage of bank and agency staff. The majority of the bank staff worked at the hospice substantively or at the service's sister hospice, so they were very familiar with the service. Staff told us bank staff who were unfamiliar with the service or agency staff completed an induction prior to commencing work.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. The medical staffing establishment of 0.8 WTE consultant and 1.0 WTE non-consultant medical staff was fully recruited to. There were also two GP in training doctors who worked in the service on six-month rotations at any one time. This ensured there was always at least one doctor onsite daily.

The service always had specialist palliative care doctors on an on-call rota during evenings and weekends. Staff told us that these were easily accessible, and they always attended the service when required.

Records

Records were not stored securely and were accessible to unauthorised persons. Records did not accurately reflect patient's needs.

Staff did not always keep complete detailed records of patients' care and treatment. Records were not always clear or up to date. We reviewed three sets of patient records; these were not always comprehensive. We found missing information such as risk assessments and care plans were not always completed or completed accurately. We noted some entries and risk assessments had not been signed by the person completing the document.

Records were not stored securely. Records were stored in unlocked drawers or in trolleys in patient's rooms, bed bay areas or in the hub area which meant records were accessible to those who were not permitted to access the records. The service provided evidence that a secure notes trolley had been ordered but had not arrived at the time of the inspection

Medicines

The service had multiple systems and processes which they used regarding how medicines were managed, prescribed, stored and destroyed, this could cause confusion and errors. Medicines were administered and recorded in line with national guidelines and the services own policy.

Requires Improvement

End of life care

There was no on-site pharmacy, the service had a service level agreement with a local pharmacy who provided pharmacist support to the hospice. Medicines were supplied by the pharmacy and direct from suppliers.

Staff followed systems and processes to administer medicines safely. We saw staff administering medications in line with the service's own medicines management and optimisation policy.

Staff completed medicines' records accurately and kept them up to date. The four medicines charts reviewed were all clearly completed and when medications were administered, they were all timed, dated and signed. Anticipatory prescribing of medications was effectively managed for patients ensuring there was no delay in patients receiving medicines.

Staff did not always follow their own medicines management and optimisation policy regarding the management, storage and destruction of medicines which we were provided during the inspection. Post patient deaths, their prescribed medicines were not always stored for the required seven days before being destroyed. We were told by two nurses that controlled drugs (CDs) from syringe pumps were emptied immediately post death into the drugs denaturing kit. This was not in line with the service's own policy which stated, "any partly used CD syringe pump medications should be capped off, placed in a clear plastic bag, labelled and sealed by two registered nurses". However, following the inspection, the service provided us with a standard operating procedure (SOP) which detailed the process followed by and described by the nurse we spoke with during the inspection. The SOP does not align with the service's medicines management and optimisations policy, which could cause confusion and varying practice amongst staff.

Controlled drugs were destroyed in line with the service's own medicines management and optimisations policy and the denaturing kit manufacturer's instructions.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The pharmacist visited the service weekly and reviewed each patient's medicines.

We were told by two members of nursing staff that staff undertook a medicines review on admission, but there was no evidence of this in the records we reviewed. We were told post inspection that these records were stored separately from the service user's own notes. We did not review these during the inspection because we did not know they were stored separately from the patient notes.

Staff learned from safety alerts and incidents to improve practice. We saw in the notes of the quality and governance subcommittee meeting minutes that alerts, and incidents were discussed.

Incidents

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

Staff knew what incidents to report and how to report them. Staff we spoke with could tell us what types of incidents they reported and how they would do it. Staff in the inpatient and hospice at home service told us that they would report incidents using an electronic reporting system.

Incidents were discussed and reviewed at the service's quality governance sub-committee meetings. We saw evidence of this in the meeting minutes we reviewed.

Requires Improvement

End of life care

Staff told us there had not been a need to undertake duty of candour in the past 12 months. They understood duty of candour and when it would need to be used, and that they would need to provide patients and families with a full explanation when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Learning from incidents was shared with staff through a quarterly report.

Are End of life care effective?

Good

TThis is the first time we have rated effective. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff mostly followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. However, we found one policy which referred to out of date national guidance. The service's pressure ulcer prevention and management policy which had been signed off as reviewed and updated on 25 May 2022, referred to out of date national guidance and guidelines. The policy referenced the nursing and midwifery council (NMC) Code 2009, this document had been updated in 2015 and again in 2018. It referenced the European Pressure Ulcer Advisory Panel (EPUAP) and the National Pressure Ulcer Advisory Panel (NPUAP) 2009, this guidance was updated in 2019. Out of date National Institute for Care and Excellence NICE guidance is also referenced, the policy included Pressure Ulcers; Prevention and Management, NICE guidance dated 2005, this guidance was updated in 2014. Policies not based on the latest national guidance place patients at risk of receiving care that is not based on the most recent evidence. Following the inspection, the service provided evidence which demonstrated that the national guidance within the procedure was correct and up to date, it was the naming of the guidance that had not been updated.

Other elements of patient care were provided in line with National Institute of Health and Care Excellence (NICE) guidelines. Anticipatory medicines for distress, agitation, seizures and pain were prescribed and given in line with NICE guidelines.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. However, only 83% of clinical staff had completed their mandatory training in the Mental Capacity Act. Staff we spoke with were able to describe the process to follow if they had concerns about a patient's mental health.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink. Patients told us they were happy with the food and drink they received, and we saw that they had water provided within their reach. Staff offered drinks to patients throughout the day and we saw that regular mouth care was provided for patients with poor oral intake.

Requires Improvement

End of life care

The hospice provided a full menu for breakfast, lunch and dinner, including hot and cold food options, and staff told us that they could provide hot and cold snacks to patients outside regular mealtimes. Patients were able to request meals that met their religious and other beliefs, such as halal, kosher and vegetarian. Staff told us they could be very flexible and prepare any food that a patient asked for if they had the ingredients.

Specialist support from staff such as dietitians could be accessed for patients who needed it. We saw evidence in patient records that referrals had been made to dietitians.

Pain relief

Staff did not assess patients regularly to see if they were in pain. They did, however, give pain relief in a timely way. They did not have systems to support those unable to communicate using suitable assessment tools. Staff give patients additional pain relief to ease pain as required.

Staff told us that patients would tell them if they had pain. But as pain assessment tools which allowed staff to use verbal and non-verbal ways to determine if a patient was in pain were not being consistently used, staff may not identify if patients who were unable to speak to staff, or who are non-English speaking, were in pain.

Staff prescribed, administered and recorded pain relief accurately. We saw evidence of this in the medication charts we reviewed during the inspection. We observed that patients received pain relief soon after requesting it.

We observed that patients' pain was discussed as part of the handover meeting including any changes that needed to be made to the patients' prescription and the effectiveness of pain relief, to ensure that pain needs were met.

Patient outcomes

Staff monitored the effectiveness of care and treatment and used the findings to make improvements and achieve outcomes for patients.

When requested during the inspection process, the service did not provide any information regarding their participation in relevant national clinical audits, or their programme of local clinical audit. However, following the inspection the service provided us with information which demonstrated they did contribute to relevant national benchmarking and undertook local clinical audits. Audits undertaken include a sedation audit, anticholinergic audit and pain – oxycodone audit.

Managers and staff carried out a programme of repeated audits including sharps, waste management, personal protective equipment and hand hygiene audits to check improvement over time. Managers used information from the audits to improve treatment. Managers shared and made sure staff understood information from the audits. We saw evidence of this in the minutes from team meetings we reviewed.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work.

Staff told us managers supported nursing and medical staff to develop through regular, constructive clinical supervision of their work. Staff told us they found the supervision sessions beneficial.

Requires Improvement

End of life care

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us they attended funded conferences and training courses relevant to their practice.

Staff told us, that managers made sure they were able to attend team meetings or had access to full notes when they could not attend.

Managers recruited, trained and supported volunteers to support the service. The service mainly had volunteers who worked in the garden during the pandemic, but there were plans to recruit more volunteers to work in the service in the near future.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care, we saw evidence these meetings took place weekly and were attended by members of the multidisciplinary team. Staff worked across health care disciplines and with other agencies when required to care for patients. For example, the hospice at home worked closely with the district nursing service and the local third sector organisations, to support end of life patients and their families receiving care in the community.

Inpatient unit staff had a good understanding of the support available from other agencies and there were referral processes in place. Hospice at home staff worked in partnership with other health and care providers locally to meet the needs of patients. There were open discussions between professionals to support patients transitioning between services.

Seven-day services

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

The doctor on duty for the day led daily ward rounds and reviewed all patients, seven days a week. There was medical and senior nurse support for the inpatient unit 24 hours a day through the on-call system. Staff could call for support from other disciplines, 24 hours a day, seven days a week.

Health promotion

Staff gave patients practical support to help them live well until they died.

The service had relevant information promoting healthy lifestyles and support on the ward. Staff provided support for individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

In the year up to July 2022, 83% of clinical staff had received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards which was slightly under the service's training completion target of 85%. Staff we spoke with could describe the mental capacity act and knew how to access the policy and get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Requires Improvement

End of life care

Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children's Acts 1989 and 2004 and they knew who to contact for advice.

Staff told us when mental capacity assessments identified that patients were unable to give consent to care and treatment, staff made decisions in their best interest, considering their wishes, culture and traditions.

Do not attempt cardiopulmonary resuscitation (DNACPR) decisions, were discussed with the patient concerned and, where consent was given, their family. The three DNACPR records reviewed contained clear evidence that patients and their families had been fully involved in the decision.

Are End of life care caring?

Good

This is the first time we have rated caring. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff interacting with patients in a way that enabled them time to ask questions, gain clarity and an understanding of treatment and care.

Patients both on the inpatient unit and the hospice at home service, said staff treated them well and with kindness, and that 'they couldn't do any more for us". Patients and families, we spoke with said staff in every part of their pathway were kind and considerate and very caring.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff told us they were able to seek support if they were unsure of the cultural needs of any patient.

Staff consistently worked together to provide compassionate care tailored to individual needs. They went above and beyond to find ways to comply with patient's wishes in the last days of life. For example, one patient's last wish was to see the house they grew up in again. The service used a virtual reality technology headset to enable the patient to virtually visit their old home. The service arranged a very short notice on site wedding for a patient who wanted to marry their partner before they died.

Staff told us they had plenty of time to spend with patients and develop relationships. Comments from patients reflected this.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Requires Improvement

End of life care

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We saw evidence of this throughout our inspection when observing staff and patient interactions.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The families we spoke with told us they felt the hospice could not have done more for them, they were always available to talk to, whenever they had questions or concerns.

Staff provided emotional support and bereavement services. They worked with patients, carers, families and friends and offered practical and emotional support. Staff spoke with them for as long as they wanted and asked them about their emotional wellbeing. They arranged for religious leaders to attend the hospice to provide emotional support. The service had links with religious leaders from many different faiths and kept a list of their contact details. Relatives told us they appreciated still being involved with the hospice after the death of their loved ones.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff told us they had enough time to sit and talk to patients about their care and answer any questions they may have.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients and their families told us they always had opportunities to express their views in their daily conversations with staff and knew who to contact if required.

Staff supported patients to make informed decisions about their care. Patients and their families, both on the inpatient unit and in the hospice at home service, gave positive feedback about the way staff supported and involved them.

Are End of life care responsive?

Good

This was the first time we have rated responsive. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The service worked with others in the wider system and local organisations to plan care. They tailored services to meet the needs of individual people and delivered the services in a way to ensure flexibility, choice and continuity of care. The hospice worked closely with the local NHS trust's palliative care team and accepted referrals from GPs, and other health and social care providers.

The service operated urgent access and rapid discharge pathways, which were responsive to patient's needs and risks. The hospice at home team provided care on the same day when possible.

Requires Improvement

End of life care

Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health conditions, learning disabilities and dementia. Staff told us the referral system worked well.

The service had systems to help care for patients in need of additional support or specialist intervention. Specialist interventions, for example lymphoedema nursing and radiology services were accessible through the service's own lymphoedema nurse or the local NHS hospital's radiology department.

The service managed the facilities and premises to the best of their ability considering the limitations of the building they were using. They had refurbished the reception, communal eating area and the patient rooms and bays to a high standard. They had developed plans to undertake a new build within the next five years to ensure the sustainability of the service for many years to come.

All side rooms were en-suite and there were wet rooms and bathrooms for the bay areas. The patient areas were spacious and allowed for several family members to attend.

The service had a range of on-site facilities, which families could use. On the inpatient unit relatives had the option of staying in the rooms with patients. Families were encouraged to use the communal kitchen areas to prepare beverages and could eat with their relatives by ordering meals from the services kitchen.

Meeting people's individual needs

The service was inclusive and mostly took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Regarding advance care plans, the service stated that all patients should receive a nursing holistic needs assessment on admission. In the three patient records, we reviewed we did not find any fully completed nursing holistic needs assessment. Following the inspection, the service provided an update on advance care plans stating the needs of the patient evolve on discussion and review, and the care plans would evolve during the patient's time at the service.

Staff had access to communication aids to help patients become partners in their care and treatment. Managers made sure staff, patients, relatives and carers could get help from interpreters when needed. A variety of leaflets were available on the inpatient unit including information about the last days of life. The leaflets had information in different languages on the back explaining that the leaflets were available in different languages.

Ward areas and side rooms were designed to meet the needs of patients living with dementia. We observed that the side rooms and patient bay areas were decorated with dementia friendly protocols in mind.

Patients were given a choice of food and drink to meet their cultural and religious preferences. There was access to halal and kosher menus. The service had suitable facilities to meet the needs of patients' families. Free tea and coffee making facilities were located in the communal area for visitors and families to use. There was also a fridge in this area for families to store food items they had brought in for patients.

The service had a complimentary therapy team who offered a range of therapies to both patients and relatives including massage.

Requires Improvement

End of life care

During the COVID-19 pandemic when there were restrictions in international travel the service arranged for deceased patients to be repatriated to their preferred place of burial. More recently the service had arranged for urgent return of deceased patients to Pakistan and India for rapid burial. A how-to guide had been developed on how this could be done and had been shared with a number of hospices.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Patients had fast track admissions 24 hours a day, seven days a week, either direct from the community or transferred from hospital.

Managers and staff worked to make sure patients did not stay longer than they needed to. The clinical team and discharge co-ordinator met daily to discuss patients' care needs. Staff discussed service provision at daily multi-disciplinary meetings. This included when appropriate patients would be discharged to their preferred place of care.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. The service had an admissions and discharge co-ordinator, who monitored and forwarded referrals and admissions to the appropriate services. Referrals came through from the local hospital, GPs or specialist nursing and community teams.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service had a complaints, concerns and compliments policy and procedure which was ratified by the board in June 2022 and due to be reviewed in 2025. Staff understood the policy on complaints and knew how to handle them. They understood the system and had access to policy and procedures to guide them in managing complaints. Staff we spoke with knew how to acknowledge complaints and concerns. We saw evidence concerns were managed in line with the policy.

Patients, relatives and carers knew how to complain or raise concerns. In patient areas the service clearly displayed information about how to raise a concern. The patients and family members we spoke with told us they knew how to make a complaint or raise concerns and felt comfortable doing so.

The service had not received any formal complaints in the 12 months before the inspection. Managers we spoke with told us how they would fully investigate and how feedback and learning would be given to the staff.

Staff could give examples of how they used concerns patients, or their families raised to improve daily practice. Staff were expected to report and escalate any concerns, so that they could be resolved or addressed immediately, if this was not possible the concern was discussed, and a solution was fed back. The weekly staff update included details of concerns raised and what the service had done to resolve them.

Are End of life care well-led?

Requires Improvement

End of life care

Requires Improvement

This was the first time we have rated well led. We rated it as requires improvement.

Leadership

Leaders did not always fully understand and manage the priorities and issues the service faced, however they had some of the right skills and abilities to run the service. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

There was a clear management structure with lines of responsibility and accountability. The board of trustees had overall responsibility for overseeing the hospice's business. They delegated day to day operations to the chief executive officer.

Staff we spoke with were very positive about the leadership team and told us that managers were approachable and visible. Staff knew the different managers and their areas of responsibility. Staff said they felt supported and gave examples of when they had received support with personal circumstances. During the inspection, we observed positive interactions between staff and managers. Staff told us they felt comfortable and able to raise any concerns they had with the management team.

We were not assured the leadership team had good visibility of the quality of care being provided. When we raised serious safety and governance concerns found during the inspection with the management team, particularly in relation to infection prevention, pain management, secure storage of records and management of consumables, leaders were unaware of these issues.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had undertaken a strategic review between July and November 2020, it was aligned with Hospice UK guidance, national strategy and the local sustainability and transformation partnership for end-of-life care.

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with some relevant stakeholders. The vision and strategy were focused on sustainability of services and were aligned to local plans within the wider health economy.

Leaders were committed to implementing the strategy, part of which was to work with others to meet people's needs. The service had been developing sustainable partnerships with the wider health and social care economy. The senior leadership team and the board of trustees had the experience, capacity and capability to ensure the strategy could be delivered. The service was in the process of reviewing its strategy at the time of the inspection and had arranged some focus groups with community members and stakeholders to gather feedback.

Strategic objectives were supported by measurable outcomes which were reviewed bi-monthly and reported to the board through the quality and governance subcommittee meeting.

Requires Improvement

End of life care

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with felt respected, supported, and valued by their leaders. Staff reported a no bullying culture and felt able to raise any concerns or issues they may have. The service had a whistleblowing policy which was available to all staff and information on how to raise concerns was available within this document.

Patients and their families felt able to raise concerns through various means. We saw evidence of them doing this and how the service responded.

When speaking with staff it was clear that their priority was focusing on the needs of the patients they cared for. Staff were passionate about making sure the service the patient received met their needs.

The service's August 2021 staff survey results demonstrated staff felt supported, listened to and asked for their ideas to improve the service.

Governance

Leaders did not always operate effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities. They had regular opportunities to meet, discuss and learn from the performance of the service.

The service did not have an appropriate system in place to ensure that patients were treated as individuals. Care plans were not always routinely and consistently completed and were not always tailored to meet the individual's needs.

The provider did not demonstrate they had oversight of the review and ratification of policies. There were three policies which, were not being adhered to by staff or had out of date references to national guidance. The pressure ulcer prevention policy was reviewed in May 2022 but contained three different references to out-of-date national guidance and was ratified by the board in June 2022. The confidentiality policy was due for review in January 2018 but was only in the process of being reviewed at the time of the inspection. The medicines management and optimisation policy made reference to 2013 General Medical Council guidance; this guidance was updated in 2021. Following the inspection, the service clarified that in regard to the medicines management and optimisation policy the guidance within the report was correct, but the reference dates had not been updated. The service also provided information following the inspection, relating to the guidance errors in the medicines management and optimisation policy and the use of a separate standard operating procedure (SOP), this SOP was submitted after the inspection.

There were also five of the service's 50 policies, which were past their review date, one due for review in July 2019. Following the inspection, the service provided us with an undated confidentiality policy which had been reviewed in June 2022, this was not provided to us when requested during the inspection.

There were various committees which reported to the board, including the quality and governance subcommittee, finance, building and estates committee, and the workforce subcommittee.

There was a lack of evidence that the trustees and leaders were reviewing data to enable them to have an insight into the service's quality management. We saw trustees and committee members discussed audits at the quality and governance subcommittee meeting, but there was no evidence they reviewed or discussed individual audit results in any depth to identify areas of good practice or areas for improvement.

Requires Improvement

End of life care

The service held bi-monthly quality and governance subcommittee meetings which were structured around the quarterly dashboard, estates log, risk management, safeguarding group, policies and audit updates. Minutes from the last three meetings were reviewed but did not demonstrate that the risks identified during our inspection had been identified or discussed. For example, these minutes made no reference to concerns about infection control cleanliness, and medicines management, risks identified during the inspection.

The service had an audit programme, we saw evidence of regular audits being undertaken in relation to hand hygiene, personal protective equipment, waste management and sharps management as well as an annual infection prevention and control audit. However, despite the service undertaking cleaning audits, they had not identified issues relating to dirt and dust in the inpatient unit which were identified during the inspection.

There was a governance meeting structure in place with governance meetings held bi-monthly. The board adopted a governance calendar to ensure that it systematically reviewed key management information and data. The quality and governance subcommittee consisted of the matron, director of nursing and clinical services, medical director, quality improvement lead, and was chaired by a trustee.

Management of risk, issues and performance

Leaders and teams did not have effective systems to manage risk. They did not always identify risks and issues.

The service had a risk register in place at the time of the inspection. The risk register was not up to date, with risk ratings that reflected the current risk status.

We noted that the master risk register did not reflect all of the risks we found during the inspection such as infection control and cleanliness. The service did not have a system in place to identify clinical risks to patients, the service's risk register did not include any known or potential clinical risks. It was unclear how the service identified or had oversight of clinical risks to patients, or if they identified the actions needed to reduce the impact of the risks. Following the inspection, the service sent us a Covid risk register which highlighted some clinical risks in relation to Covid infections only.

Information Management

The service did not always collect reliable data and analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

Information governance training formed part of the mandatory training programme for the service, and staff we spoke with were able to discuss their responsibilities in relation to information management. However, whilst the service had ordered a new lockable notes trolley, they had not put in place mitigations to ensure notes were secure until the arrival of the trolley.

The did not have a holistic understanding of performance, which resulted in systems which were not integrated with patient and family views and information on quality. Integrated management information systems were not used to support informed decision making. Clear performance measures were not always evaluated and reported on.

The service had appointed a Caldicott Guardian who understood the Caldicott principles. Caldicott principles are fundamental rules and regulations that guide a patient's confidentiality. They are the basic rules every healthcare personnel must follow to ensure there is no breach of confidentiality. However, staff did not always follow these principles to ensure patient confidentiality.

Requires Improvement

End of life care

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service engaged with patients through patient surveys. The feedback from these surveys was reviewed and themes and trends identified to improve the future service the hospice provided. Feedback was overwhelmingly positive and identified the care and support given to all patients using the hospice's services.

The hospice was planning a stakeholder event, to gather feedback from the community on their future strategy. They had also held events to gather feedback from the community on their experience of end-of-life care in the area in partnership with other third sector and charitable organisations.

The hospice worked collaboratively with local health and social care groups to deliver services needed in the area during the pandemic. The service also worked with the local NHS hospital to identify suitable patients for referral to the hospice as early as possible. This ensured that patients received the right care in the right facility and aimed to reduce hospital admissions for people near or at the end of life.

The service actively engaged with staff, to ensure their views were reflected in the planning and delivery of services and in the shaping of the culture.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

The medical director along with local GPs had developed a website for use by patients, families and clinicians. This provided information regarding the best local, national and international resources relating to palliative and end of life care, in a way which was easily accessible for clinicians and patients in North West London.

The chief executive officer was the initiator of the Integration of Hillingdon end of life care single management structure. This work included a coordination hub with a single point of contact phone number for all services, available to support patients in the last two years of life.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment All mandatory training levels did not meet the service's target and all staff had not completed their mandatory training.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Clinical audits are not undertaken • All policies were not within their review date and did not always contain the latest up to date national and best practice guidance. • Stock control and rotation systems were not adequately in place to manage the use by dates of consumables. • Service users' records were not complete and were not always individulaised to patients' specific needs. • Service user records were not stored securely. • Risk register did not include all risks with dates, risk scoring and evidence of owner ship of the risk. • Data was not always collected and presented in a format that manager and staff could understand and use to inform decision making. • The service was not visibly clean. Infection prevention and control measures were not in place or being used effectively and cleaning chemicals were not always stored appropriately and safely.