

St Joseph's Hospice







Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good	
Are services safe?	Requires improvement	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive?	Good	
Are services well-led?	Good	

Overall summary

St Joseph's Hospice is operated by St Joseph's Hospice Association.

The hospice cares for over 200 patients and their families each year from across Liverpool, Knowsley and Sefton. St Joseph's Hospice is registered as a charity but receives 40% of its funding through the NHS.

St Joseph's Hospice has 29 beds across three units. St Francis House has two units. St Francis Upper has 10 rooms on the first floor and St Francis Lower has eight on the ground floor. San Jose has 11 rooms, all on the ground floor. We inspected adults' services on all units.

We carried out an unannounced visit to the hospice from 7 to 9 August 2018. We inspected this service using our

Summary of findings

comprehensive inspection methodology. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We inspected all five key questions.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided by this hospital was hospices for adults.

Services we rate

Our rating of this service improved. We rated it as good overall because:

- The service had sustained improvements seen at the previous inspection in December 2017.
- We saw the service had continued to improve how medicines were given to patients and recorded. The non-medical nurse prescriber had their competencies regularly checked and reviewed annually by a medical supervisor.
- Care records showed patients' care plans reflected their needs, preferences and choices. Staff completed care monitoring charts and recorded patients' level of pain, fluid intake and output and how much food they got through two hourly 'comfort rounds'.
- Since the last inspection the service had introduced the 'safety thermometer' to monitor patient outcomes and service performance on pressure ulcer care and falls.
- Staff received a good level of support through regular supervision and annual appraisal. Staff told us they received good support from the clinical director and the inpatient unit manager.
- We saw that consent was sought from patients and their advocates around key decisions and recorded

in care plans. Staff followed the principles of the Mental Capacity Act 2005 and made appropriate applications under Deprivation of Liberty Safeguards when patients lacked capacity to consent to care and treatment.

- The service continued to store confidential information securely. Staff respected confidentiality and updated records and discussed care in the nurses' station where they could not be overheard or overlooked.
- Systems and processes for assuring standards at the hospice were embedded. Trustees and senior managers showed awareness of issues and had acted to mitigate against these. Improvements and challenges were effectively monitored through finance and clinical governance sub-committees.
- The service ensured there were sufficient number of staff on duty to care for patients. We saw they were actively recruiting qualified nurses. The management had closed one unit to any admissions until enough qualified nurses were recruited to provide safe care and treatment.
- We saw the service had introduced structured handovers of care of patients between shifts which were thorough and attended daily by a senior manager.
- The service had developed links with other providers and hospices in the local area to share learning and good practice. There were many examples of positive engagement with the local community.

However, we also found areas of practice that require improvement:

- Though the service had improved how medicines were given and recorded staff still had to handwrite onto medicines charts and a second member of staff did not always check and sign these records. There was no information for health care assistants on how often to apply topical preparations and creams.
- We saw that used and full oxygen cylinders were not stored in line with the manufacturer's best practice guidelines on storage of medical gases.

Summary of findings

- Not all communal areas that were used by patients had call bells so patients could not call for assistance if they fell or became unwell when alone in these areas.
- Volunteers who directly supported patients did not receive safeguarding for adults and children training.
- Staff did not use a recognised tool to assess the level of pain experienced by patients who could not speak.
- The service did not provide facilities for patients from different religious or cultural backgrounds.

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.

Ellen Armistead

Deputy Chief Inspector of Hospitals (Hospitals North)

Summary of findings

Our judgements about each of the main services

Service

Hospices for adults

Rating

Good



Summary of each main service

Hospices for adults was the only activity provided at this location.

The hospice had three units providing specialised long-term end of life care for 29 patients. At the time of our inspection 21 patients were accommodated.

We rated this service as good because it was effective, caring, responsive and well led although safe requires improvement.

Summary of findings

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Good 

St Joseph's Hospice

Services we looked at

Hospices for adults

Summary of this inspection

Background to St Joseph's Hospice

St Joseph's Hospice is operated by St Joseph's Hospice Association. It is the oldest and largest hospice on Merseyside providing long-term specialised end of life care for patients with a range of life-limiting conditions. It also offers longer-term care for some patients with complex needs.

The association was founded in 1962 and opened St Joseph's Hospice on the current site in 1974. It is a charitable hospice in 12 acres of woodland in Thornton, Merseyside. The hospice primarily serves the communities of Liverpool, Knowsley, Sefton and West Lancashire.

It has a contract for five beds with Liverpool Clinical Commissioning Group CCG (CCG). At the time of our inspection the contract for five beds with South Sefton CCG had ended and the service was negotiating a new contract. CCGs are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.

At the time of our inspection the ground floor of St Francis House was closed whilst the service recruited sufficient registered nurses. The service accommodated 21 patients, 10 on the upper floor of St Francis House and 11 on San Jose.

The hospice has had a registered manager in post since December 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. They have legal responsibility for

meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is run. At the time of the inspection, the manager was on a planned leave of absence and an interim manager had been appointed and CQC were notified on 1 August 2018.

At the previous inspection of 4,5 and 7 July 2017 the provider was found to be inadequate and the service was placed in 'special measures' by CQC. We place services in special measures to ensure they do not continue to provide inadequate care. Services placed in special measures are inspected within six months of the publication of the inspection report.

Following the inspection in July 2017 we issued an urgent statutory notice requiring the provider not to admit any further patients to St Joseph's Hospice.

We inspected St Joseph's Hospice on 11 and 12 December 2017 and found it had improved and rated it as 'requires improvement'.

In light of the improvements found at the December 2017 inspection we saw the service had met the conditions of the urgent statutory notice. We did not rate the service as 'good' as this would require a longer track record of consistent good practice.

We carried out an unannounced comprehensive inspection on 7, 8 and 9 August 2018.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, a specialist medicines inspector and a specialist advisor with expertise in end of life care. The inspection team was overseen by Nick Smith, Head of Hospital Inspection.

Information about St Joseph's Hospice

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

- Accommodation for persons who require nursing or personal care

Summary of this inspection

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

Staff work on a rota across all three units. Two units were open at the time of our inspection, St Francis House Upper and San Jose. The service does not provide care or support in the community.

St Joseph's Hospice has a board of trustees and two sub-committees, clinical governance and finance. There is a chief executive officer, clinical director (registered manager) and inpatient unit manager.

The service has been inspected eight times and the most recent inspection took place in December 2017.

During the inspection we visited St Francis House and San Jose. We spoke to 23 staff including senior managers, registered nurses, health care assistants and ancillary staff. We also spoke to five trustees including the Chair and heads of the clinical governance and finance committees. We also spoke to three volunteers and the volunteer manager.

We spoke to eight patients and relatives and received three 'tell us about your care' comment cards. We also received one 'I want great care' form and one typed feedback letter.

We observed care and treatment and looked at seven patient care records and five medicines administration records as well as service performance data.

Activity (July 2017 to June 2018)

- In the reporting period July 2017 to June 2018 there were 48 patients with a life limiting illness who received care and treatment at the hospice.
- The hospice provided care to 40 patients over 65 years old and 8 patients aged between 18 and 65.
- There were 34 admissions to inpatient beds.

St Joseph's Hospice employed 15 registered nurses, 26 health care assistants and 51 non-clinical staff. It also had 120 volunteers with two having direct patient contact. The accountable officer for controlled drugs was the registered manager.

Track record on safety (July 2017 to June 2018)

The service had three never events, all three with no harm. A 'never event' is a serious patient safety incident that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. The three events related to potential medicines errors which were found by staff before medicines were administered to patients so there was no harm to the patient.

The service reported two serious incidents. As an independent provider, St Joseph's Hospice is required to report serious incidents to CQC. They also reported both incidents to the South Sefton Clinical Commissioning Group who then reported one through the Strategic Executive Information System (StEIS). The second serious incident related to supply of medications from an external source and no harm was caused. Serious incidents include 'never events' (serious patient safety incidents that are wholly preventable).

The hospice reported two deaths to CQC in the period that were followed by the involvement of the coroner.

There were no incidents of confirmed hospital acquired infections. However, there was one suspected infection outbreak among three patients in March 2018. Infection control measures were used and samples tested which did not show signs of infection.

There were six complaints in the reporting period, two of which were upheld.

St Joseph's Hospice 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?

We rated safe as requires improvement because:

- Although we found the service largely performed well, we found some areas for improvement. This meant we could not give it a rating higher than requires improvement.
- The service did not have reliable systems and processes to look after all equipment well. They did not store medical gases, such as oxygen, in line with the manufacturer's best practice guidance. We saw oxygen cylinders were stored outside, where they were open to the elements, and full and empty cylinders were not separated.
- There was a risk that staff may not respond appropriately to medical emergencies as not all communal areas and prayer rooms had call bells. This meant that patients using these rooms on their own could not call for help in event of an accident.
- The service did not always follow best practice around administering medicines. Staff had to handwrite medicines on the medicine administration record chart. This meant there was a risk that errors could be made when information was transcribed. We found that a second staff member did not always check and sign these records.
- Staff did not always follow best practice when giving and recording thickening powders to patients who were prescribed them because they had difficulty swallowing.

However,

- The service provided mandatory training in key skills to staff and made sure they completed it. Mandatory training compliance rates were above 90% for all groups of staff.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff knew how to escalate concerns to senior staff in line with the safeguarding policy.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. We saw staff adhered to 'bare below the elbows' guidance. Staff and visitors had access to alcohol hand gel at the entrance to each unit.
- Staff completed and updated comprehensive risk assessments for each patient.
- The service had enough nursing and care staff with the right qualifications, skills, training and experience to keep people

Requires improvement



Summary of this inspection

safe from avoidable harm and to provide the right care and treatment. They were actively recruiting registered nurses and had closed one unit until they could ensure sufficient nurses were available to provide safe care and treatment.

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and provided information on patients' individual needs, preferences and choices. This was an improvement from our previous inspection.
- The service had continued to make improvements to their medicines management processes with guidance from the local clinical commissioning group medicines management team.
- The service had introduced safety monitoring. Staff collected safety information and shared it with staff, patients and visitors. Information on the number of falls was displayed clearly on each unit.

Are services effective?

Good



We rated effective as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. We saw staff followed National Institute of Health and Care Excellence guidelines for end of life care for adults in prescribing and giving pain relief.
- Staff gave patients enough food and drink to meet their needs and improve their health. We saw that menu cards gave a choice of hot and cold food and other options were available on request. Staff used special feeding and hydration techniques when necessary and helped patients to eat and drink when needed.
- Staff assessed and monitored patients through two hourly 'comfort rounds' to see if they were in pain. Staff we spoke to were aware of signs of pain and discomfort in individual patients.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. The service used the 'I want great care' survey to monitor patient and carer feedback.
- The service made sure staff were competent for their roles. Managers had appraised all staff's work performance in the last 12 months and held supervision meetings with them to provide support and monitor the effectiveness of the service. All registered nurses had their professional registration checked in the last 12 months.

Summary of this inspection

- Staff of different kinds worked together as a team to benefit patients. The GP for the hospice and a consultant from a local hospital trust attended the weekly multidisciplinary team meeting.
- Staff understood how and when to assess whether a patient had capacity to make decisions about their care. We saw they made appropriate best interests decisions and applications for Deprivation of Liberty Safeguards when a patient could not give consent.

However,

- Staff did not always accurately monitor and record the amount of fluid patients had taken.
- The service did not use a formal assessment tool to help staff to assess if patients who could not speak were in pain.

Are services caring?

Good



We rated caring as good because:

- Staff cared for patients with compassion. Feedback from patients and their relatives confirmed that staff treated them well and with kindness. Staff demonstrated excellent communication skills and we saw compassionate and caring interactions between staff and patients and relatives.
- The service had received many thank you cards which showed that patients and relatives felt staff treated them with kindness, compassion and care and showed high levels of professionalism and support to families and patients.
- Staff provided emotional support to patients and relatives to minimise their distress. The family support officer and volunteers offered ongoing emotional support that was not time limited and tailored to individual circumstances and preferences.
- Feedback from patients and carers showed they valued and appreciated the additional emotional support offered by the family support officer.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients told us them and their relatives had been involved in developing their care plan and we saw evidence of this in patient care records.

However,

- Though volunteers supported patients to access the grounds and communal areas some patients told us they were not able to access them as much as they would like to.

Summary of this inspection

Are services responsive?

Good



We rated responsive as good because:

- The service planned and provided services in a way that met the needs of local people. We saw the service had plans to develop the site to provide new services that took into account the emerging health care needs of the local population.
- The service took account of patients' individual needs. We saw that care plans were comprehensive and person-centred. Patients' individual needs and choices were recorded in 'This is me' records available to all staff.
- The service ensured that patients were encouraged to maintain relationships with people that mattered to them. Visiting hours were flexible to encourage friends and family to visit and fold up beds were provided for carers and relatives to stay with loved ones.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. We saw leaflets advising patients and relatives how to make a complaint were available on every unit and posters were displayed around the site.

However,

- Staff did not have access to translation services for patients and relatives who did not speak English.
- The service did not provide facilities to meet the cultural and spiritual needs of patients of different faiths and cultural backgrounds.

Are services well-led?

Good



We rated well-led as good because:

- Managers at all levels had the right skills and abilities to run a service providing high-quality sustainable care. The service had ensured appropriate cover for the planned absence of senior managers.
- The service had a vision for what it wanted to achieve which had been developed with staff and the local community. The service had started to plan how it could improve the site and care and treatment and staff had been consulted on these plans.
- Managers across the service promoted a positive culture that supported and valued staff. Staff told us that the culture had improved since the last inspection and was open and transparent. We saw positive relationships between staff and managers.

Summary of this inspection

- The service systematically improved service quality and reviewed clinical performance and quality through the clinical governance sub-committee.
- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected. The service had clinical and business risk register and the clinical risk register was reviewed at the clinical governance sub-committee.
- The service collected, analysed, managed and used information well to support all its activities. Information was stored electronically on secure systems with access limited to staff who needed the information.
- The service actively engaged with the local community through annual events held at the hospice open to any member of the community. It engaged with staff and local organisations to plan and manage services and collaborated with partner agencies and other local hospices effectively.

However,

- We saw that one risk was not accurately rated on the clinical risk register.
- Not all staff were aware of the whistleblowing policy and how to raise concerns about patient care and treatment.
- Several trustees were near the end of their tenure on the board and the service had not developed succession plans or plans to recruit new trustees.






Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Hospices for adults

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

Are long term conditions safe?

Requires improvement 

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

Mandatory training

- The service provided mandatory training in key skills and made sure everyone completed it.
 - The service delivered mandatory training via an online system. Staff could access 34 different training modules which included basic life support, information governance, bullying and harassment, equality and diversity, end of life care, safeguarding adults, safeguarding children, deprivation of liberty and medicine management.
 - The service also provided classroom based learning and used external trainers to provide training in subjects including basic life support, fire safety, deteriorating patients, conflict resolution, transforming integrated and palliative end of life care and safe handling of medicines.
 - The service provided data on mandatory training completed by registered nurses, health care assistants, laundry, housekeeping and kitchen staff from April 2017 to July 2018. We reviewed the data and saw mandatory training modules covered the key skills and knowledge needed for their roles. The service tailored the training to the staff roles and responsibilities.
- We reviewed training records for 12 registered nurses, one nurse had not completed any mandatory training as they were a new starter still being inducted. Registered nurses were required to complete 34 modules. We saw four registered nurses had completed all modules. All registered nurses had completed over 65% of the modules with three nurses having only one outstanding module.
 - Health care assistants were required to complete 25 mandatory training modules. We reviewed training records from April 2017 to July 2018 and saw the completion rate was 98%. All kitchen and laundry staff had completed mandatory training.
 - Managers told us that basic life support training for nine staff would be provided by an external trainer in September 2018.
 - The system generated an automatic email to staff members when a module was due or close to expiring. The inpatient unit manager received a monthly training report outlining the outstanding training modules for all staff and sent email reminders and discussed this in team meetings.
 - We saw that training levels were a standing agenda item at the clinical and quality improvement meeting held quarterly. We reviewed the minutes for the meeting in November 2017 and saw that this was discussed.
 - The service used volunteers to help with its day to day running. Volunteers did not undertake mandatory training modules but completed an induction process on their first day specific to their area of work. This included a health and safety checklist covering important information such as emergency exits, fire

Hospices for adults

alarms, muster points and first aid provision.

Volunteers were also told about relevant policies such as mobile phone, gifts from patients, bullying and harassment, drug and alcohol, confidentiality and data protection. Volunteers signed to say they had read and understood the policies. We saw all 26 volunteers who volunteered on the hospice site had completed the sign off sheet.

- The service told us it was introducing new mandatory training for volunteers which would cover safeguarding, health and safety, equality and diversity, hand hygiene, dementia training, information governance and fire safety. They had plans for all volunteers to complete this by the end of 2018.

Safeguarding

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Some staff had training on how to recognise and report abuse and staff we spoke to knew how to raise safeguarding concerns.
- Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 The fundamental standard of safeguarding states; “children and adults using services we regulate must be protected from abuse and improper treatment. Providers should establish and operate systems and processes effectively to ensure this protection and to investigate allegations of abuse as soon as they become aware of them.”
- The clinical director was the service safeguarding lead. They had completed level three safeguarding adults and children training. The interim director and inpatient unit manager had also completed level three safeguarding training.
- We saw that the organisation had a clear referral pathway for safeguarding concerns including during out of hours periods. Senior nurses provided cover seven days a week over 24-hours and could contact the inpatient unit manager out of hours to escalate safeguarding concerns. The inpatient unit manager also worked one weekend a month. This meant staff could access a level three trained safeguarding member of staff out of hours.
- Staff we spoke to said they felt confident that they could recognise patients at risk of harm or abuse and were able to name several different types of abuse. All staff said they would escalate concerns to the senior member of staff on duty which was in line with the safeguarding policy.
- The safeguarding policy was in date and available in written form at each nursing station in both St Francis and San Jose buildings. The policy did not specify the level of safeguarding training required by staff but managers told us staff were required to complete level one and two adult safeguarding training. We saw that of 12 registered nurses, 11 had completed level one safeguarding adults training and seven had completed level two. All health care assistants had completed safeguarding adults level one training and 73% had completed level two.
- We saw that three safeguarding referrals had been raised between February and March 2018 and none since this date.
- Though the hospice was for adults only it had taken a proactive approach in recognising potential children’s safeguarding concerns and required staff to undertake this training also. This was in line with the Royal College of Paediatrics and Child Health - Safeguarding children and young people intercollegiate guidance which suggested that all “all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers” be trained to level 2. It was also in line with the Care Quality Commissions roles and responsibilities in safeguarding adult and children which stated; “Every organisation and person who comes into contact with a child or adult has a responsibility and a role to play to help keep children and adults safe.” Eight registered nurses had completed safeguarding children level one training. Staff had access to support from managers and senior nurses who had completed level three safeguarding children training.
- We were told by managers and staff that befriending volunteers, kitchen and domestic staff who regularly entered patient’s bedrooms had not undertaken safeguarding training. We reviewed training records for these staff that confirmed this.

Hospices for adults

- The service told us that they planned to give all volunteers safeguarding training and this would start in September 2018. Mandatory safeguarding training for volunteers would be reviewed every three years.
- However, two volunteers who worked directly with patients had completed up-to-date disclosure barring system checks.

Cleanliness, infection control and hygiene

- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- Staff observed 'bare below the elbows' guidance and alcohol hand gel was available at the entrance to each unit. We observed care and treatment and saw staff washed their hands before providing care and treatment to patients. Staff had access to personal protective equipment such as disposable gloves and aprons and used this appropriately. However, on St Francis we saw some staff did not wash their hands when they moved between patients to provide care and treatment.
- Staff told us they were regularly assessed on their hand hygiene by the infection control champion. We reviewed the hand hygiene audits for April, May and June 2018. We saw compliance with hand hygiene standards had improved from 87% in April 2018 to 96% in June 2018. We saw hand hygiene audits were discussed in the clinical governance meeting minutes. This meant the service was following national guidance and could be confident it was protecting patients, visitors and staff from the spread of infections.
- The infection control champion told us that they were supported by the service to attend three separate infection control courses. They were implementing an updated cleaning checklist for medical devices. The service had also introduced a new method for the disposal of dirty linen as a result of learning from this training.
- We reviewed cleaning audits and associated action plans from February, April, May and June 2018 and saw compliance with cleaning standards had

improved from 89% in February 2018 to 96% in June 2018. The action plans clearly identified actions required and taken to address any issues and dates for follow up inspection.

- We saw that the medical device cleaning schedule in Saint Francis Upper unit had been completed weekly by staff throughout July 2018. We saw staff used green 'I am clean' labels to identify equipment which had been cleaned and the date it was cleaned.

Environment and equipment

- The service had suitable premises and looked after them well. It was supported by an external Health and Safety officer who had supported the service to introduce appropriate policies, systems and processes. We reviewed policies on Health, Safety and Welfare and Fire Safety Management. These were comprehensive, current and reviewed annually.
- The hospice is situated within 12 acres of land, with a large woodland as a backdrop and gardens and lawns with colourful flower beds which patients were able to look out on to. The hospice had worked with a local charity to set up bee hives in the grounds and had written an anaphylaxis policy in case of an allergic reaction by visitors or patients.
- St Francis upper floor had two lifts, one for visitors and patients who could walk and a second for patients that were on stretchers. We saw this lift was in working order, easily accessible and its width and length was suitable for a stretcher. However, we found a wheelchair was placed directly opposite its doors partially obstructing the exit. This was rectified immediately and we saw no further obstructions.
- Two emergency 'evac u sleds' were clearly visible on the wall of the upstairs unit. These are devices to help staff move patients who cannot use stairs in the event of an emergency when lifts cannot be used.
- The doors to clinical areas within the buildings were secure and accessed using a fob. There were also buzzers which staff monitored and operated for visitor access. The main entrance to St Francis which was open during the day was locked at night. The fob system tracked the person entering and exiting the building and we saw the service kept records of this for security purposes.

Hospices for adults

- All rooms were individual with washing facilities, electric beds, wall mounted televisions and several arm chairs. Each room contained a locked medicine cabinet. All had wide aspect windows which maximised light and views of the grounds for the patients and their relatives. Each room had a sign on its door consisting of the number as well as a picture of a tree.
- Within the grounds there was also a designated laundry facility, a bereavement office and a fundraising office.
- We clearly saw the previous Care Quality Commission inspection ratings displayed on several noticeboards including in the main reception areas and found that fire and safety information was clearly visible in both buildings.
- We saw noticeboards for relatives which displayed the organisations statement of purpose, key principles of nursing, food hygiene ratings and family support worker information. We also found various leaflets were wall mounted and readily available next to the noticeboards.
- There were communal areas in each building including a large dining area and lounge. The communal areas did not all have call bells. We saw that the lounge and kitchen area in St Francis Upper did not have a call bell and staff told us the area was not used by patients. However, we saw one patient enter the room during our inspection.
- There was a prayer room in both buildings available for patients and relatives however there was no call bell which meant that should a patient be left to reflect alone they were unable to call for help. We told the service about this during our inspection and call bells were installed the same day.
- There was a secure nursing office in each area. The office contained medicine fridges and confidential information in locked cupboards such as staff files and patient's medicines charts and individual care records.
- Staff told us that specialist equipment such as syringe drivers and hoists were readily available.
- The facilities manager had oversight of all facilities, premises and maintenance issues. They reported monthly to the managers meetings and the reports were reviewed by the external Health and Safety Officer. All reports, inspections and audits were available to staff online and in printed folders in the facilities office. The sites and facilities team met bi-monthly to discuss any issues.
- We reviewed the health and safety folders and saw they were divided into reports of clinical and non-clinical equipment. We saw the clinical equipment compliance test schedule and saw hoists, baths and sluices services were completed in March 2018. We saw legionella testing was carried out in March 2018 and there was a current certificate of registration and evidence of six monthly water hygiene engineer visits.
- Beds, mattresses and recliners were serviced annually and the next service was confirmed for September 2018. We saw portable appliance testing had been done on 461 appliances in October 2017.
- We reviewed inspection and test reports for all equipment including syringe drivers, nebulisers, suction machines, slings and blood pressure monitors. These were up-to-date. Fridges including those used to store medicines had been serviced in July 2018. We observed staff giving pain relief using a syringe driver and saw that the checklist and maintenance record was completed for the syringe driver they used.
- The service maintained a waste register. This was important as it meant the service was following Department of Health guidance on the safe storage and disposal of healthcare waste.
- An external Fire Safety Officer completed a site specific risk assessment in March 2015 and the service updated this when required. We saw the last fire risk assessment had been completed in May 2017. We saw evidence that planned and unplanned fire drills took place. The service completed a post evacuation assessment following every drill. We reviewed completed assessments and saw they contained the evacuation time, the names of people involved, if the roll call had taken place and any issues. We saw evidence that the facilities manager followed up issues with the relevant people. For example, we saw emails sent to contractors who had not evacuated during a drill reminding them of the policy and procedure.

Hospices for adults

- The service did not have personal evacuation plans for patients in event of a fire but had completed a fire exit strategy, a site risk assessment and a contingency plan for emergencies. Fire escape signs were clearly displayed and fire extinguishers available in all buildings.
- The facilities manager organised and supervised external contractors. During our inspection we saw external contractors carrying out repair work to premises.
- However, the premises did not have clear signs indicating bathrooms and sluice rooms. This means that patients could accidentally enter rooms that contained chemicals or substances hazardous to health. We raised this with managers at the time of the inspection and signs were put on the rooms the next day.
- The service did not store medical gases in line with the manufacturer's best practice guidance. We saw full and empty oxygen cylinders stored together in a secure area outside both St Francis and San Jose units. The area was open to the elements and the cylinders were visibly dirty. This meant there was a risk that an incorrect cylinder could be collected by staff and that cylinders had to be deep cleaned before use.
- The booklet contained risk assessments, monitoring and action plans for pressure sore prevention, mattress selection, manual handling, functional mobility, moving and handling, falls, use of bedrails, entrapment in bedrails, malnutrition universal screening tool (MUST), mouth care, continence and infection control. The booklet was fully completed in all the patient care records we reviewed.
- We saw staff additionally assessed and responded to risks to individual patients as appropriate. For example, we saw a patient who could not use a call bell due to their condition and risk of injury being observed regularly and placed in a room that staff frequently walked past. We saw evidence that this had been discussed with the patient's family. However, the risk assessment and care plan for this was not documented. We raised this with nurses during the inspection and this was rectified immediately and a risk assessment and care plan completed.
- Patients wore wrist bands which alerted staff to risks such as allergies and if the patient was at high risk of falls.
- During our inspection the hospice accommodated some patients who required resuscitation if they became acutely unwell. Staff could tell us what to do if this happened, for example they would start basic life support and call 999 for immediate assistance. All nurses and health care assistants were trained in basic life support. Staff had access to emergency oxygen, oxygen tubing and masks and a pocket mask if they chose to deliver breaths during cardiopulmonary resuscitation.

Assessing and responding to patient risk

- Staff completed and updated risk assessments for each patient. They kept clear records and asked for help when necessary.
- We saw staff completed an initial risk assessment within 12 hours of a patient being admitted and repeated this when a patient's circumstances changed. All patients assessed as high risk were reassessed daily.
- We observed a patient being admitted and saw a comprehensive management plan was actioned with excellent communication between the patient and family and the GP and nursing staff.
- Staff used a risk assessment booklet for all risk assessments they carried out. We saw the booklet contained guidance on using the individual patient risk assessment tool including risk reduction strategies and rationale for identified risk factors.
- The hospice did not have a defibrillator on site. A defibrillator is a device that gives a high energy electric shock to the heart through the chest wall to someone who is in cardiac arrest. This high energy shock is called defibrillation, and it's an essential lifesaving step. We saw evidence that an application was submitted in July 2018 for funding for a defibrillator and the service planned to have one by September 2018.
- We saw the service had developed a draft cardiopulmonary resuscitation policy that had not yet been agreed and signed by the board of trustees.

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- A multidisciplinary team which included a specialist consultant and GP as well as nurses reviewed patients weekly. The GP also attended the hospice three days a week and reviewed all patients. We observed an assessment of a patient with worsening symptoms. Staff and the GP carried out a comprehensive medicines review, which was documented and changes to medicines instigated immediately.

Nurse staffing

- The service had enough nursing and health care staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- We checked a random sample of 12-hour rotas for nursing and health care staff. We saw the levels of cover were in line with the service's designated establishment. All shifts we reviewed had sufficient registered nurses and health care assistants on duty to provide safe care and treatment. Senior nurses were on duty seven days a week.
- Staff told us they received their rotas four weeks in advance and once received would usually not be altered. Rotas were paper based and available in a file within the nursing office on each unit.
- We saw that staff rotated across both San Jose and St Francis buildings. Staff told us they now worked as one team across the hospice. They told us they felt they could provide effective care and treatment as they knew all the patients' needs and preferences well as they worked in both units.
- We found that between May and July 2018 agency nursing staff were used on 28 occasions. This was confirmed in the clinical governance meeting minutes and we saw this was a standard agenda item. Managers told us that agency staff completed a checklist induction on arrival at the hospice as well as a familiarisation with the unit, patients and relevant policies and procedures. Mandatory training was undertaken by the agency and this was checked by managers through regular contact with the agency.

- The hospice reported low sickness absence rates for registered nurses and health care, 0.6% between April and June 2018. Turnover rate for all staff between April 2017 and March 2018 was 2.4% which was below the service's target.
- The service had recognised registered nurse staffing levels were low and was actively recruiting at the time of our inspection. Lack of registered nurses was escalated to the corporate risk register and as part of its action plan a recruitment drive was underway with a planned open day advertised. The service displayed a large banner at the entrance of the site stating they were recruiting staff and we saw interviews for permanent and bank nurses took place during our inspection.
- Managers had taken the decision to close eight beds on St Francis Lower unit in response to the low levels of registered nurses. They told us the unit would not open until they could recruit enough registered nurses to staff the unit safely.

Medical staffing

- No medical staff were employed by the service and medical provision for patients was via the local GP who attended the unit for 12 hours over three days per week.
- Out of hours provision was through the national helpline 111. Staff told us they informed the helpline regularly about patients and their individual care plans to reduce unwanted returns to hospital in the event of a deteriorating condition. This meant that the most appropriate response in line with patient wishes could be met during the evenings and weekends should a patient deteriorate and medical assistance be required. Staff could also access GP cover through the out of hours GP service.

Records

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- We saw patient records were stored securely in the nursing office. The office was accessed by a coded key pad with only authorised staff given the code. We

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observed staff completed care plans and records in the nursing office, where they could not be overlooked by people who did not have the right to access the records.

- Care records we reviewed contained comprehensive and person-centred care plans which clearly identified patients' emotional, social and spiritual needs alongside their physical health needs. Staff completed care plans appropriately and we saw they recorded when care was carried out in line with the care plan. Staff reviewed care plans monthly.
- Staff could access patient specific information from the care plan which included information on communication, psychological and mental health and end of life care. All care records contained a 'this is me' document that detailed the patient's needs and preferences and took account of any additional needs such as dementia and behavioural needs.
- We reviewed seven patient care records and found that consent to share information with relevant people including relatives and other healthcare professionals had been obtained and recorded.

Medicines

- A medicines inspector looked at how medicines were managed across the two units open at the hospice. We checked the medication administration records (MAR) for five patients and personal care files for four patients. We inspected storage conditions and checked quantities of medicines for four patients. We spoke with six staff and looked at medication policies and audits.
- Since the last inspection, the hospice had continued to make improvements to their medicines management processes with guidance from the local clinical commissioning group medicines management team. Their external audits demonstrated an improving picture. New practices had been introduced including new documentation and auditing. We found some issues during the inspection but staff took immediate action to rectify the problems.
- Treatment rooms were visibly clean and tidy and medicines were stored securely. The hospice had recently re-opened the upstairs in St Francis following redecoration and bedside medicine lockers were provided.
- Staff completed daily temperature checks in store rooms and bedrooms to ensure that medicines were stored correctly. Records were clear and there was evidence that stock checks were being completed. We checked a sample of medicines stocks, including controlled drugs, and these were correct. There were no gaps in records indicating that people were receiving medicines as prescribed.
- A bespoke medicine administration record (MAR) had been created and was in use. Though the records had some improvements, staff had to handwrite medicines on the charts until the pharmacy could provide printed labels. There is a risk that errors could be made when information is transcribed, so it is important to always have a second staff member check and sign these records. We found that this was not always happening.
- Both San Jose and St Francis units had an incoming medicine record book. Staff recorded all deliveries of medicines, including the amounts received each month. A medicines communication book was used to record all contact with GP, hospitals and pharmacies when placing orders and an escalation process was in place, when medicines were delayed. Staff told us that communication with external sources was time consuming and analysis of the issues was ongoing. At the time of the inspection staff were waiting for medicines to be delivered for two patients and fortified drinks for a third with no stock. Medicines were received in time for their next dose.
- We checked the records for patients who were prescribed a powder to thicken their drinks because they had difficulty swallowing. We found discrepancies in the records for one patient, where care staff were unsure of the correct consistency required. This was escalated and nurses ensured this issue was immediately addressed. Patients are at risk of choking if drinks are given that are the wrong consistency.
- We looked at records for patients who were prescribed medicines to be taken when required. Additional

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information to guide staff was available for oral medicines however, there was no information for care staff who applied topical preparations. For example, when a cream was prescribed 'when required', a body map was completed to demonstrate where to apply but not how often this should be done. Nurses assured us that this would be addressed.

- We spoke with staff who were positive about the changes and said they were included in decisions. Changes were communicated via team meetings and email updates. Lessons had been learned and procedures changed to ensure that risks were reduced. However, some of the written procedures did not reflect new processes.
- The non-medical prescriber had a fit for practice development plan which was reviewed annually by a medical supervisor. Staff told us they received regular supervision from their medical supervisor and they felt more confident and supported. We saw evidence that the medical supervisor had supported the non-medical prescriber in their fitness to practice revalidation and non-medical prescriber education since December 2017. This was an improvement from our previous inspection.
- We saw that medicines prescribed for agitation and distress were in line with National Institute of Health and Care Excellence (NICE) guidance for anticipatory prescribing for adults in the last days of life.
- Controlled drugs were checked by a registered nurse and a health care assistant with level two national vocational qualifications in health care, in line with the controlled drugs policy. Staff told us they updated their competency assessment for checking controlled drugs every six months.
- We observed a medicine round and saw that staff wore red 'do not disturb' aprons. Staff followed all processes in line with the medicines management policy. Medicines given by percutaneous endoscopic gastrostomy (PEG) tubes were given appropriately and patients' identification was checked before giving medicines. Patients' symptom control needs such as pain, nausea and vomiting were assessed by staff during the medicines round.
- We saw that the medicines team from the local clinical commissioning group carried out regular medicines

audits. The service also had a six-monthly controlled drugs audit completed by an external company. We reviewed the audit completed in July 2018 and saw staff followed the administration of controlled drugs policies and procedures correctly and auditors commented that 'policies have been incorporated well into practice, ensuring safe, auditable practice for handling and recording controlled drugs administration'.

Incidents

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learnt with the whole team and wider service. When things went wrong, staff apologised and gave patients honest information and feedback.
- We reviewed the patient and staff incident report forms from April 2016 to July 2018. We saw 22 patient incident forms had been completed and clearly documented the nature of the incident. Each incident had actions taken and the outcomes of the actions documented and they were reviewed and signed by the clinical director.
- We reviewed two detailed investigation reports and incident files. We saw the incidents had been investigated thoroughly by managers and all staff involved were interviewed and signed statements taken. We saw evidence that duty of candour was applied and letters were sent to relatives and carers offering further support. 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.
- The hospice reported three 'never events' between July 2017 and June 2018, all with no harm. A 'never event' is a serious patient safety incident that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event reported type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. The hospice reported never events and serious incidents to CQC through statutory notifications.

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- The local clinical commissioning group (CCG) reported one serious incident to the Strategic Executive Information System (STEIS). Serious incidents include 'never events' (serious patient safety incidents that are wholly preventable). The service also notified CQC when the incident occurred. A full investigation had been carried out using root cause analysis and an action plan developed which was shared with all staff. We saw evidence that changes had been instigated as a result of this investigation such as structured handovers between staff at the beginning of each shift.
- No safeguarding concerns had been raised by the organisation since April 2018 however three were raised during February and March. Two were related to medication errors, one of which was reported to STEIS as detailed above. Staff told us that lessons from this had been cascaded down to them through monthly team meetings and individual feedback. For staff members unable to attend the meetings we were told that a widespread email was sent to all staff as well as the minutes of the meeting printed and displayed on the noticeboard within the staff area.
- The service reviewed incidents to identify themes and trends. Managers told us that they had seen several incidents took place when the service was staffed by agency nurses. They had addressed this by instigating a recruitment campaign and delaying the opening of additional beds until they were able to recruit sufficient registered nurses.
- Staff knew the process for reporting incidents and felt confident they would be supported in doing so. This meant that an open and transparent culture was emerging across the staff groups and widespread unity felt.

Safety Thermometer (or equivalent)

- Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.
- The organisation had appointed a 'react to red' pressure sore champion. Staff had received pressure sore training which included a DVD and questionnaire and had been positively received by staff members. The service had a named tissue viability nurse. React

to red posters were clearly displayed across each area and a pressure ulcer safety cross was displayed which demonstrated the number of days since the last pressure sore within the organisation.

- We saw that in August 2018 there had been no incidences of pressure sores. Staff updated patients care plans daily with the Waterlow score, a nationally recognised tool which gives an estimated risk of the patient developing a pressure ulcer. Wound dressing care plans were used where appropriate.
- Staff told us that 'react to red' was instigated five months ago and we saw that the service had an audit tool to use once six months data had been submitted to assess the effectiveness of the approach.
- Staff monitored catheter associated urinary tract infections (CUTIs) through individual catheter care plans and catheter passports which we saw were completed where appropriate.
- During the inspection the service provided information on number of CUTIs, pressure sores and falls from May 2018 to July 2018. No patients had developed a pressure sore, though three patients had been admitted with a pressure sore and received appropriate care and treatment for this. The service did not have any patients who acquired a CUTI. This indicates that measures taken to prevent pressure sores and CUTIs were effective.
- The service told us that two patients had fallen between May 2018 and July 2018.

Are long term conditions effective? (for example, treatment is effective)

Good 

Our rating of effective improved. We rated it as **good**.

Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

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- We saw anticipatory medicines for distress, agitation, seizures and pain were prescribed and given in line with National Institute of Health and Care Excellence (NICE) guidelines for care of the dying adult in the last days of life and palliative care for adults.
- We saw patients had a clear personalised care plan that reflected their needs and was up to date. Staff delivered care to patients in the last days of life that met the 'five priorities of care of the dying person'. Staff took account of patients' spiritual needs within end of life care plans. Individual care plans took account of symptom control, psychological, social and spiritual support and we saw evidence of discussion with patients and relatives recorded in care plans. This gave us assurance that care plans were agreed with all the relevant people and carried out with the consent of the patient. We saw staff delivered care and treatment agreed in care plans with compassion and kindness.
- The hospice took part in the Cheshire and Merseyside palliative and end of life care network audit and was part of the clinical guidelines group. The clinical director attended regular meetings with the directors of the two other hospices in the area to share best practice and learn from each other. The inpatient unit manager shared learning and good practice in regular meetings with other hospice managers.
- We observed staff assisting patients to eat and drink at meal times and used the short observational framework for inspection (SOFI) tool to observe a patient assisted to eat lunch. The SOFI tool is used to review services for people who have conditions that mean they cannot reliably give their verbal opinions on the services they receive. During the observation we collected data in two minute time frames. We saw that the patient's general mood state was neutral and that 44% of the interactions with the health care assistant were positive. The patient was engaged in the task at all times. The health care assistant ensured they were in a comfortable and suitable position to eat. The health care assistant offered food and drink to the patient at an appropriate and comfortable pace and checked if the patient wanted and liked the food before offering it.
- We reviewed the menu cards for lunch and saw patients were offered a choice of hot and cold main meals and puddings. The menu was rotated every four weeks, soft and pureed options were available. The food was nicely presented on individual trays with sauces and gravy in a separate container. Staff used red trays to indicate patients who required assistance to eat and drink.
- Staff we spoke to showed awareness of individual patients' food preferences and made adjustments to accommodate this such as putting food in a bowl to assist a patient to eat.

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' preferences.
- We saw staff used the malnutrition universal screening tool (MUST) to assess the food and hydration needs of patients. These were completed in all but one of the seven patient records we reviewed. We informed managers about this during the inspection and this was escalated immediately to nursing staff.
- Staff recorded the fluid patients had been given and taken on fluid balance charts. These were complete in all patient records we reviewed but we found one patient had not had the amount of fluid taken recorded accurately.
- Staff completed a specific percutaneous endoscopic gastrostomy (PEG) care plan for patients who had a PEG to receive nutrition. We saw staff followed the service's policies and procedures when giving nutrition by PEG and also when caring for the PEG.
- Patients could choose tea from an extensive list of hot and cold food options including homemade soups and main meals. Staff told us if a patient wanted something that was not available they would order it for them. Patients told us they enjoyed the food and had access to drinks throughout the day.

Pain relief

- Staff assessed and monitored patients regularly to see if they were in pain and gave additional pain relief to

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ease pain. Staff assessed patient's pain in two-hourly comfort rounds and could tell us the signs and symptoms of pain in patients who could not speak or describe their symptoms.

- We observed two handovers between shifts and saw that staff discussed patients' level of pain or pain symptoms. Staff also asked patients about pain during medicines rounds.
- We reviewed care records and saw patients had appropriate pain care plans and staff documented when pain was present. Staff recorded when as required medicines were prescribed and given for pain relief. We also saw staff gave pain relief medicines appropriately by percutaneous endoscopic gastrostomy (PEG) tube for patients who had difficulties swallowing.
- Staff prescribed and gave anticipatory medicines for pain relief and end of life care as required and in line with National Institute of Health and Care Excellence (NICE) guidelines.
- We observed a medical review attended by the GP and a registered nurse. Staff conducted a comprehensive review of medicines which included pain relief and symptom management. Staff documented the review in the patient's care records.
- However, the service did not have any formal pain assessment tool for patients who were not able to speak.

Patient outcomes

- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- Patients and their relatives completed the 'I want great care' survey. Posters were clearly displayed in each unit and the survey was available in every patient room along with an envelope so patients could submit the survey in confidence. We saw volunteers giving copies of the survey to patients and supporting them to complete them. The outcome of the survey for June 2018 was clearly displayed on noticeboards in both units and showed a five-star rating.

- 'I want great care' is a website where services and patients can submit reviews about the care and treatment patients received. The review has categories on dignity/respect, involvement, information, caring, trust and the quality of the support staff as well as an overall recommendation. We reviewed the 'I want great care' website and saw that 103 reviews had been submitted since October 2015 and the service had been awarded a five-star rating.
- The family support worker reviewed the feedback from the 'I want great care' survey and fed back any relevant clinical or patient care and treatment issues to the clinical director for action.
- The local clinical commissioning group (CCG) audited the hospice annually to provide feedback on patient outcomes and quality of care and treatment. We saw that the CCG clinical quality team had looked at patient records and care plan documentation in November 2017 and found them to be of good quality.

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 monitor the effectiveness of the service.
- Between June 2017 and July 2018 100% of nurses and health care assistants had received an appraisal. We reviewed training records and saw that 10 out of 12 registered nurses had received training in how to conduct appraisals in the last 12 months.
- All nursing staff had their registration with the nursing and midwifery council checked and 33% of nurses had completed the revalidation process.
- We saw that registered nurses and health care assistants had completed additional role or skill specific training. This included the six steps to success end of life care training and transforming integrated palliative and end of life care training.
- Registered nurses had attended clinical skills training days throughout July 2018 and we saw the service had plans to implement a journal review system to share learning and best practice among staff.

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- We saw staff had accessed external classroom based medicines management training as well as mandatory online training and 13 registered nurses and health care assistants had completed the safe handling of medicines foundation course.

Multidisciplinary working

- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- We saw the weekly multidisciplinary team meeting was attended by registered nurses, the GP for the hospice and the consultant in palliative care from a neighbouring hospital. Staff told us that if necessary the community matron or staff from the community palliative care team would also attend the meeting.
- We observed the weekly multidisciplinary team meeting and saw positive working relationships between nursing and medical staff. We saw that the care and treatment of every patient was discussed at the meeting and a management plan put in place.
- We observed staff working effectively with hospital staff and the GP when a new patient was admitted. We saw staff communicated with the hospital team to ensure the patient was admitted with the correct documentation and medicines. Staff told us if patients had to transfer to hospital they sent a letter to the hospital with a copy of the medicine chart and other appropriate forms such as do not attempt resuscitation forms. If appropriate a member of staff would accompany the patient to hospital.
- Staff worked effectively with colleagues in other services such as mental health to deliver care and treatment. We reviewed a patient record that showed staff had worked with the local mental health team to get an assessment of a patient's mental health needs and put a tailored care plan in place.
- The service had a family support officer who liaised with families and carers and took part in multidisciplinary meetings to ensure the families point of view was represented and reviews took account of all the patients' needs not just medical ones. The family support officer provided support to families on dealing with grief. They advised families on how to take care of themselves and also how to raise any safeguarding concerns.
- The family support officer was proactive in thinking of ways in which they could support patients and carers. They had presented a proposal to start a support group for longer term patients which had been accepted by the clinical director and which they were presenting to the patients to see how they would like the group to be developed.
- We observed two handover meetings and two multidisciplinary team meetings and saw that health improvement priorities such as alcohol use, obesity and smoking were discussed. We saw staff gave appropriate advice on diet and weight gain and alcohol use to patients and recorded this in the patient records.

Consent and Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood how and when to assess whether a patient had capacity to make decisions about their care and treatment. They followed the service's policy and procedures when a patient could not give consent.
- The Mental Capacity Act 2005 allows restraint and restriction to be used if they are in a person's best interest. Extra safeguards, Deprivation of Liberty Safeguards (DoLS), are needed if the restriction and restraint used will deprive a person of their liberty. Staff we spoke with could describe the process of assessing capacity and the requirements for obtaining consent if the patient was assessed as lacking capacity.
- We reviewed four patient records and saw that in all four mental capacity assessments had been carried out appropriately. Two patients had deprivation of liberty safeguards in place and for two, staff had submitted the application and were waiting for a decision from the local authority. We saw the mental

Health promotion

- Staff identified patients who needed extra support and discussed changes to patients' care and treatment with patients and their carers. The service provided support to families and carers to maintain their own health and wellbeing.

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capacity assessment for a patient with dementia had been carried out on admission by a registered nurse and the GP and clearly recorded the reason for the assessment.

- We saw staff had involved relatives who had lasting power of attorney in making an appropriate application for deprivation of liberty safeguards. Lasting power of attorney is when someone is appointed to make decisions on a person's behalf when the person lacks mental capacity.
- We saw do not attempt cardiopulmonary resuscitation (DNACPR) decisions were recorded on appropriate forms and completed accurately in all the patient records we reviewed.
- In all patient records we reviewed we saw consent was signed by either the patient or someone with lasting power of attorney before putting bed rails in place. This meant that patients were not deprived of their liberty by being restrained in bed without their consent.
- The service ensured staff received training in assessing mental capacity and deprivation of liberty safeguards. We reviewed training records and saw that 75% of registered nurses and 100% of health care assistants had completed mental capacity act training in the previous 12 months. Only one registered nurse who was newly appointed had not yet completed deprivation of liberty safeguards training. All the health care assistants had completed deprivation of liberty safeguards training.

interactions between staff and patients and relatives. Relatives told us they were impressed by the care shown by staff towards their loved ones – 'they'll do anything for her'.

- We reviewed 20 thank you cards sent since January 2018 and saw that bereaved relatives commented positively on the care and kindness shown to their loved ones. We saw comments such as 'thank you for all the outstanding care and love to her' and 'it was a comfort knowing she was being looked after by a team of such wonderful, professional, caring people'.
- Patients told us staff responded in a compassionate and timely way when they experienced discomfort or distress. They told us they answered call bells quickly and went out of their way to help them.
- We saw that staff protected patients' privacy and dignity when providing care and treatment and patients confirmed this. Patients told us that staff treated them with dignity and respect when carrying out personal care and they felt comfortable with staff delivering this. We saw staff closed the doors to patients' rooms when carrying out care and treatment and knocked before entering. Patients told us staff always asked permission before carrying out any care or treatment.
- We observed care and treatment provided to one patient using the short observation framework for inspection (SOFI) tool. The SOFI tool is used to review services for people who have conditions that mean they cannot reliably give their verbal opinions on the services they receive. We observed the care given in two-minute timeframes over a 38 minute period. We saw that for 94% of the time the patient's mood was neutral. The patient's mood changed to positive for 6% of the time following intervention from a member of staff. The staff member had entered and greeted the patient positively and noted they were fiddling with the bedsheets. The staff member returned with a teddy bear and asked the patient if they would like to hold that. The patient responded positively to this and showed signs of improved mood. We also saw that staff engaged with the patient for 33% of the observation and all interactions were neutral or positive.

Are long term conditions caring?

Good 

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

Compassionate care

- Staff cared for patients with compassion. Feedback from patients and their relatives confirmed that staff treated them well and with kindness.
- Patients we spoke with told us that staff were very caring and compassionate and we saw positive, caring

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- We received three 'tell us about your care' comment cards from three relatives during the inspection. They all praised the care given by staff to their relatives.
- Patients told us they liked the environment in the hospice including their rooms and the grounds. However, some patients told us they would like the opportunity to go out into the grounds more but could not as they could only go outside with relatives or volunteers. Patients also told us staff did not encourage them to use communal areas so they sometimes felt isolated or stuck in their rooms.

Emotional support

- Staff provided emotional support to patients to minimise their distress. Patients told us they had opportunities to discuss any bad news with staff and they were given appropriate support when receiving bad news. Patients told us that staff provided comfort when they were upset and often sat with them talking and holding their hand when they were upset.
- Staff encouraged relatives and friends to visit to provide emotional support and allowed them to bring in pets. During our inspection we saw a patient accessing the grounds with his relative and pet dog. We saw patients were supported to access and maintain their social networks. For example, we saw staff liaising with friends of a patient to encourage them to take her to the bingo. This was recorded in the patient care records and discussed at handover and the multidisciplinary team meeting so that all staff were aware that this was important to the patient.
- The family support officer gave emotional support to patients, their families and staff. They were a trained counsellor and worked flexible hours to respond to the needs of patients and their families. They told us they would visit families at home to provide support if appropriate.
- The family support officer gave examples of the type of support they had offered to patients and families. This included supporting them with pensions and benefits queries, counselling, helping with funeral arrangements and other practical issues such as how to write a will. They sent out cards to bereaved relatives and did not have a time limit on how long a bereaved relative could access support. They told us of one relative who still accessed emotional support 12 months after the death of their loved one.
- Befriending volunteers provided emotional support to patients and were supervised by the family support officer. The attended weekly and could provide aromatherapy, wash and style patients' hair or just offer a listening ear. Every two months an organisation attended with 'pets as therapy dogs' to provide emotional support to patients.
- The family support officer sent an annual questionnaire to bereaved families to gain feedback on the support services. We reviewed the most recent results from 2017 and saw all comments were extremely positive and relatives commented upon the high level of care and support received by the family support officer and care staff. They appreciated the long-term support that the family support officer provided particularly attending funerals and allowing them to call after their loved one had passed for support.
- The service held a remembrance service in a local church every November. All relatives who had lost someone were invited and staff reported that they received positive feedback about this.
- The 'light up a life' event took place annually in December at the hospice. This was widely advertised in the local press and could be attended by anyone in the community who had lost a relative. Staff told us this was well attended.
- A clinical psychologist had facilitated a session for all staff to talk about experiences of end of life. This had been well received and the service is in the process of initiating regular debrief sessions.

Understanding and involvement of patients and those close to them

- Staff involved patients and those close to them in decisions about their care and treatment.
- Relatives and carers told us that flexible visiting hours meant they could be involved in their loved one's care

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and there were fold up beds for relatives to stay with loved ones if they wished. Relatives could also have a meal with their loved one at a small cost and we saw positive communication between staff and relatives.

- We saw evidence in patient care records that relatives were involved decisions about patients' care and treatment and in developing their care plans. Relatives told us that staff answered questions about care and treatment openly and signposted them to other people if they could not. We saw that relatives had signed statements to say they were involved in developing the patient's care plan. We saw that relatives had said they appreciated the support from staff and involvement in their loved one's care and treatment - 'it was all the little extra touches which made it such a special time when we know we could have found it all very difficult'.
- Patients and their relatives told us they had been contacted by the family support officer and felt they could access support from them to get the information they needed about treatment and services.
- We spoke to patients who told us they felt staff listened to them and gave examples of when their care or treatment had changed after they had given feedback and asked questions. They told us they had been involved in completing the 'this is me form' and that staff followed the information in the form.
- The Hospice used the 'I want great care' survey form to gain feedback from patients and relatives in addition to the complaints and compliments procedure. The 'I want great care' survey can be completed via the form, or online by visiting a website.
- However, three relatives commented that they felt communication between the senior management team, patients and carers could be improved.

Are long term conditions responsive to people's needs? (for example, to feedback?)

Good 

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

Service delivery to meet the needs of local people

- The service planned and provided services in a way that met the needs of local people, however they were not proactive in meeting the needs of people from different cultural and ethnic backgrounds.
- We saw the service had closed its overseas operations to reinvest in the hospice so they could develop it to meet the needs of the local community. Senior managers showed us plans for future developments that showed an awareness of the needs of the local population. They planned future services that provided space for people in the community to access social activities and therapies to address the needs of people with life-limiting illnesses and dementia who were socially isolated and to support carers.
- The service was working proactively with the local clinical commissioning group (CCG) to identify gaps in provision in the local area. We saw the service had reviewed the impact of the new dynamic purchasing system and presented the results, including when patients had not been able to access appropriate care, to the CCG. They had made suggestions to the CCG to improve the access to beds in the hospice and were meeting with commissioners to discuss this at the time of our inspection.
- Though the hospice did not have specific facilities for families they provided fold up beds so families could stay with their loved ones. Staff told us families and friends could have a meal at the hospice for a minimal cost.
- However, the service did not have facilities for patients from different cultural backgrounds or faiths other than Christianity. Though the service had removed Christian and Catholic iconography from communal areas and the grounds, patients and relatives of no

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faith or a different faith could not access an appropriate space to practise their beliefs. The hospice had a chapel that was set up for use as Christian prayer and reflection space. There were quiet rooms designated as multi-faith but these also maintained Christian iconography.

- Staff did not have access to translation services for patients' who did not speak English, though all patients did speak English at the time of our inspection.

Meeting people's individual needs

- The service took account of patients' individual needs. We saw that care plans were person-centred and signed by the patient and their main carer.
- We reviewed care plans and saw that services were coordinated with other agencies to provide care to patients with more complex needs. For example, we saw evidence that the local mental health team had assessed a patient. The assessment and mental health care plan were clearly documented in the patient care record along with evidence of staff following the care plan.
- Staff monitored and reviewed the changing needs of patients through regular 'comfort rounds'. We saw that staff increased the frequency of these rounds to respond to patients' individual needs. We saw that staff had increased the frequency of comfort rounds for a patient with dementia who could not be given a call bell due as he fiddled with items meaning there was a risk of accidental injury. Staff completed an individualised risk assessment and care plan for this specific situation during our inspection.
- We saw that all patients had a 'this is me' booklet that was available to all staff and outlined their individual needs and preferences. Staff had received training on working with patients with specific needs such as dementia awareness.
- We observed a patient being admitted to the hospice from hospital and reviewed the support to the patient and relatives during the transfer of care. We saw a comprehensive management plan was put in place and there was excellent communication between the GP, the hospital and hospice nursing staff and the

patient and family. We saw the patient's anxiety ease and the family told us they felt relief that their loved one was in an appropriate environment receiving the appropriate, expert care and treatment.

- Staff encouraged patients to maintain relationships with people that mattered to them. We saw evidence of discussion in handovers of staff liaising with relatives and friends of patients to ensure they could do activities together such as attending bingo. Volunteers supported patients to access activities in the grounds and local community that they wanted to do.
- We saw clear discussion in handover meetings about the preferences of patients who were approaching the end of their life. Staff had ensured the spiritual needs for a patient had been met and facilitated a priest to attend and deliver sacrament. We saw staff supported bereaved families with practical arrangements such as liaising with funeral directors and registering deaths.

Access and flow

- People could access the service when they needed it. Arrangements to admit and treat patients were in line with good practice.
- Managers used an escalation tool to assess the level of demand and activity in each clinical area. This was completed at the beginning of every shift. Staff were allocated to different areas if necessary to meet the needs of patients.
- The service had accommodation for five patients which was directly paid for by local clinical commission groups (CCGs). CCGs purchased accommodation for additional patients on a case by case basis. At the time of our inspection the service did not have a waiting list for admission.
- Senior managers expressed concerns that the purchasing system used by one CCG made it difficult for patients to be admitted to the hospice in a timely manner, though there was a fast track system for urgent admissions. They had conducted a local review of the impact of this on patients and saw that it meant some patients were waiting for admission or were not

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admitted before they died. Senior managers had shared this with the CCG and were meeting with the CCG at the time of our inspection to develop an action plan.

- We saw the service had a new admission policy. This was in line with other hospice care providers in the area and met the needs of local people with life-limiting illness. The hospice now had clear admission criteria and patients were assessed by the continuing healthcare team after three months. This was an improvement from the previous inspection.
- We saw that the processes used to admit patients were effective and staff liaised with other agencies and professionals. The consultant in palliative care from a neighbouring hospital attended weekly multidisciplinary team meetings and staff contacted them or the wards at the hospital to escalate any issues or concerns when a patient was admitted.

Learning from complaints and concerns

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- We reviewed the complaints policy and saw it was relevant, up-to-date and clearly outlined the complaints process and steps people could take if unhappy with the outcome of a complaint. We saw posters and information booklets on how to make a complaint were displayed around the unit and patients and relatives we spoke to told us they knew how to make a complaint and would be confident to do so if necessary.
- The service received six complaints between July 2017 and June 2018. Of these, three were managed under the formal complaints procedure and two were upheld. Three complaints were resolved without formal action. We reviewed details of the three complaints without formal action and saw the service had investigated and responded to the person raising the complaint. We saw that complaints were discussed at the clinical governance sub-committee and reported at the next full board meeting.
- We reviewed the complaints record file and saw evidence that all complaints had received an initial response within 48-hours. We saw that outcomes had

been identified that highlighted organisational as well as individual learning and these had been reported to the clinical governance sub-committee. We saw everyone who had made a formal complaint received a final letter outlining the service's response to the complaint and action taken.

- Staff told us that lessons learned from complaints were shared in team meetings, recorded in the communication book and sent by email. Managers discussed lessons learned from complaint with the individual staff involved and identified individual actions or learning needs.

Are long term conditions well-led?

Good 

Our rating of well-led improved. We rated it as **good**.

Leadership

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. The service was overseen by a board of trustees led by the chair. The senior leadership team was made up of the chief executive officer, a clinical director and an inpatient unit manager who managed the service on a day to day basis.
- Nursing leadership was provided by the clinical director and the inpatient unit manager. The clinical director was a registered nurse with a background in hospice care and attended the clinical governance subcommittee.
- Leaders were visible and approachable. We saw and staff commented on positive relationships between staff and leaders. Trustees and managers regularly visited and walked round the units talking to staff and patients. The interim clinical director attended a handover daily and trustees attended the quarterly service of remembrance held at the hospice for staff and families of patients who had died.
- We spoke to trustees and saw they came from diverse backgrounds with a range of relevant skills and experience. For example, trustees had experience in financial management and accountancy, the media and public relations, health service management and

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palliative care. Trustees had a limited tenure and some were getting close to the end of their tenure. There was no plan of succession for the board of Trustees but the service planned an away day for the trustees and senior leadership in September 2018 and told us this would be discussed then.

- We reviewed records that showed fit and proper persons requirements including enhanced disclosure and barring service checks had been met for all trustees and senior managers in the last 12 months. Fit and proper persons requirements require services to ensure that directors and trustees who have responsibility for ensuring the service meets fundamental standards of care are fit and proper to carry out that role.
- The chief executive officer had recognised various learning styles of the management team and had implemented tailored training accordingly such as coaching or mentoring. This provided some succession planning of the leadership team and the senior leadership team could provide sufficient cover for all roles. However, we found that succession planning was currently not fully developed and embedded.
- All leaders we spoke with had a clear understanding of the challenges to quality and sustainability of the service. They could identify actions to address these such as investing in staff terms and conditions.
- Staff we spoke with felt connected to the service as a whole and described themselves as one team. This was an improvement from previous inspections when staff worked in silos on their own unit.
- However, we received comments from three relatives that senior management were not always approachable and did not ensure all carers felt involved in the improvements being made.

Vision and strategy

- The service had a vision for what it wanted to achieve and had started to plan how they could turn it into action. Plans were developed with staff and local community groups.

- The service had a clear view of its vision and strategy which included growing its retail estate to support its predominantly charitable income. It had recently disinvested in overseas services to enable it to focus on and support its vision and strategy.
- The future vision had been discussed and developed with the board and staff had been consulted and changes made due to their suggestions. We saw funding had been obtained to support development of the future vision but there were no workable plans to turn it into action at the time of our inspection. Senior leaders acknowledged that the focus for the previous 12 months had been on improving safety and performance and they only now felt able to plan the future vision and strategy.
- The chief executive officer told us he was developing a five-year plan that took into account the emerging health care needs of the local population and potential increase in demand.
- We saw the service had workable plans to improve recruitment of qualified nurses so they could open all units. The service had held recruitment days, used social media to promote the hospice and engaged with a recruitment agency and the local university to encourage applications. It recognised the increasing usage of social media and planned to tap into its function especially around recruitment.

Culture

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Everyone we spoke with told us there had been an improvement in the culture since our previous inspections. Staff at all levels told us the culture was transparent and open and they felt supported, respected and valued.
- Staff told us morale had improved since our previous inspection and we saw cooperative, supportive relationships between staff. Staff felt proud to work for the hospice and told us they felt proud of its reputation in the community and the changes they had made since previous inspections.
- There were mechanisms to provide staff with the development they needed and the service monitored

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appraisal rates. Appraisals are important as they provide the opportunity to acknowledge the work staff have done and offer encouragement for them to strive to high levels of achievement as well as manage their performance.

- We reviewed incident and investigation reports and saw that the service applied duty of candour appropriately. 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 we spoke to were aware of the term and could give examples of when the duty of candour would be applied.
- The service had a whistleblowing policy which was available to all staff. However, not all staff we spoke to knew how to raise concerns.

Governance

- The service had effective structures, processes and systems of accountability to support the delivery of good quality, sustainable services. This was an improvement from our previous inspections.
- The service had introduced a new governance framework with two sub-committees, clinical governance and finance that reported to every board meeting. This enabled a greater focus on patient care, quality and risk.
- We reviewed minutes of the clinical governance sub-committee and interviewed the chair of the committee. We saw the committee was attended by three trustees and the clinical director and inpatient unit manager and all aspects of compliance, safety, safeguarding and quality were discussed. Service improvements and partnerships were also discussed at the clinical governance sub-committee.
- Staff told us the committee had met on an ad hoc basis to discuss specific clinical incidents such as when a recent missed dose of medication happened and that all board members were informed immediately by email of any serious incidents or notifications to CQC.
- Each sub-committee met quarterly one week before the board meeting and presented a report to the full

board meeting. Senior managers told us that trustees offered constructive challenge at board meetings. Trustees told us they felt the quality of information and reports to the board had improved since leaders had introduced the new governance framework and since our previous inspections.

- The service had clear lines of governance and accountability from board through sub-committees to senior managers and to all staff. Staff were clear about their roles and responsibilities. Staff knew what they were accountable for and who they reported to.
- We saw that staff could report issues and concerns to the board through the structure but also directly through monthly open forum meetings.
- The service had 120 volunteers in various roles including the charity shops. Two volunteers had direct patient contact and we saw they had completed a disclosure and barring service (DBS) check. A DBS check allows employers to check if people applying for voluntary or paid roles working with vulnerable people have a criminal record. This is important because it helps the service decide if it is safe for a potential volunteer to work with vulnerable people.

Managing risks, issues and performance

- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with the expected and unexpected.
- Senior leaders and managers demonstrated an awareness of risks and performance issues and had identified and carried out action to address key issues. For example, the use of agency nurses had been identified as a theme in incidents due to medicines errors. Managers had decided not to open an additional unit until they could recruit new registered nurses to reduce the use of agency nurses.
- Risks and performance were reviewed at the clinical governance sub-committee and also through ad hoc additional committee meetings in response to specific incidents. These committees submitted reports to the board meeting.

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- We reviewed minutes of the last three board meetings and saw incidents, risks and performance were discussed. We saw investigations were discussed and the board and governance sub-committees involved in developing action plans.
- The service maintained a clinical and a business risk register. Risk registers were a standing agenda item at every board meeting and both registers were reviewed by the board when any changes were made. We reviewed both risk registers and saw they provided a comprehensive and thorough assessment of key risks. We saw the risks recorded on the risk registered aligned with what staff told us was on their 'worry list'. However, we noted that one risk recorded on the clinical risk register was not accurately rated. We brought this to the attention of leaders who stated they would review the risk at the next board meeting.
- The hospice had plans to ensure continuity of care in an emergency. We reviewed the business continuity plan which provided a comprehensive framework for the service to respond to an event which disrupted service and contained plans to maintain critical services to patients. The plan was up-to-date and reviewed annually.

Managing information

- The service collected analysed, managed and used information well to support all its activities.
- Policies and procedures were available and accessible on the service's shared drive and in files in the nurse's offices. Important information such as safety updates and performance reports were shared in team meetings and handovers.
- The service attended quarterly contract monitoring meetings with a local clinical commissioning group (CCG) and was developing performance criteria with the CCG at the time of our inspection.
- Trustees also carried out quarterly inspections of services which enabled them to identify performance issues and areas of concern and gave staff an opportunity to raise issues directly to them.
- The service monitored performance on falls, pressure ulcers and urinary tract infections and reported these

through the clinical governance sub-committee to the board. This performance information was clearly displayed on the units and shared with staff in team meetings.

- We saw there were effective arrangements to ensure that notifications were submitted to CQC as required and saw evidence of discussion with staff on how and when to send notifications in the minutes of clinical team meetings.

Engagement

- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner agencies effectively.
- The hospice worked in partnership with other services to ensure they effectively met patients' needs. The service had developed links with a local psychiatric hospital having recognised the potential gap in hospice services various people with drug and alcohol issues may experience. As part of this initiative representatives from the service had attended service user group meetings in a bid to raise awareness and visibility of the services available. There were also plans for staff to shadow psychiatric care workers to build skills and experience in supporting patients with these issues.
- The views of staff were reflected in the planning and delivery of service. For example, staff had been consulted on and suggested changes to plans to develop the site in future. Staff could attend a monthly open forum meeting with senior managers and a trustee. The meeting had no set agenda and staff could raise any issues they wished to about the service and its delivery. Senior leaders described these meetings as warm but challenging and we saw that staff of all grades attended.
- We saw many examples of positive engagement with the local community. The hospice held events throughout the year that were attended by patients, families and local people. In summer they held an annual 'teddy bears picnic' in the grounds attended by local children and their families. Local schools had attended the hospice at Christmas to sing carols for

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the patients. The service had worked with a local community group to install bee hives in the grounds as a way of bringing more community groups and members of the public into the hospice.

- The service held an annual thank you day for all the volunteers. Volunteers came from the local community and were recruited by a mixture of leaflet dropping, poster campaigns, social media and open days.
- We saw positive and collaborative relationships with external partners such as the community palliative care team and local hospitals. External partners attended multidisciplinary team meetings and the service shared information on challenges with them to improve services. The service had worked with The Reader Organisation to train volunteers to lead reading groups for patients and their families.

Learning, continuous improvement and innovation

- The service was committed to improving services by learning from when things went well or wrong and promoted training and innovation.
- We saw that the service had implemented and embedded several improvements since our previous inspections including introduction of structured handovers at the beginning of each shift, improvement in medicines management, new training opportunities for staff, clear and robust governance structures and the use of person-centred care plans.

- The service had developed effective working relationships with other hospices in the area. Managers had met with a nearby hospice to share good practice and had introduced a rotation system where staff from each organisation would work in the other to learn from best practice and suggest improvements.
- Staff told us the service had engaged with two local hospitals to develop closer working relationships and to develop operating models and patient pathways that improved the quality of end of life care people received.
- The service had participated in an external review by the local clinical commissioning group regarding a medicines error. We saw that the service had taken a full and active part in the investigation and root cause analysis. The service had implemented the action plan from the review and implemented changes to handovers and medicines checks in response.
- We reviewed two investigation reports and saw that an investigation had been carried out in each case and statements taken from all relevant parties. We saw actions were recorded, duty of candour applied and families had been offered support.
- Though the service did not hold mortality reviews all deaths were reviewed and discussed at the weekly multidisciplinary team meeting.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should assure themselves medical gases are stored safely and securely in line with best practice guidance.
- The provider should assure themselves patients have access to a call bell at all times.
- The provider should act to mitigate the risk when staff handwrite medicine labels and transcribe medicines into medicine administration charts.
- The provider should assure themselves the correct dose of thickening powder is given to patients and it is recorded accurately.
- The provider should maintain an accurate record of the amount of fluids given and taken by all patients.

- The provider should assure themselves patients who cannot speak have their pain levels accurately assessed and recorded.
- The provider should develop workable plans to turn their vision and strategy into action.
- The provider should assure themselves all staff are aware of the whistleblowing policy and how to raise concerns about patient care and treatment.

We found things that the provider should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement or to improve service quality.

- The provider should provide facilities and identify a space to meet the spiritual and cultural needs of patients and relatives of different faiths and cultural backgrounds.