The Rotherham 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?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

Rotherham Hospice is operated by Rotherham Hospice Trust. The service provides hospice care for adults. The hospice cares for over 2,200 patients and their families from across the Rotherham and surrounding areas. Rotherham Hospice is registered as a charitable trust and also receives funding from the NHS.

The hospice has 14 inpatient beds. They also support 200 to 300 people per month in their own homes. We inspected both the inpatient unit and services provided in people's homes during this inspection.

We carried out an unannounced inspection on 9 and 10 March 2019 using our 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 domains.

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

Summary of findings

needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

Services we rate

Our rating of this service improved. We rated it as **Good** overall because;

- The service had addressed all of the issues found at our last inspection in 2016 and had continued to monitor these areas carefully.
- Medicines were well managed. They were given to patients when needed and recorded appropriately. Those giving medicines had their competencies checked regularly by a medical supervisor.
- Care plans put the person and those close to them at the heart of their care and took account of their physical and spiritual needs and choices. Staff completing care plans did so accurately and with people's active involvement and consent.
- The service was responsive to the needs of patients. Good communication between doctors and nurses working in the community and in the hospice itself, meant that moving between services was straightforward and people received joined up planning for their care.
- The hospice had a dedicated and responsive staff and volunteer team who protected patients' privacy and dignity, and ensured they were given enough to eat and drink. People told us that the care they received was good.
- The hospice worked well with other organisations to ensure people received good quality care. Strong links with local voluntary groups and the local hospital meant that patients could access the right services for them and those close to them.
- The service was supporting local care homes by providing advice and guidance. We saw that less people were being admitted to hospital unneccesarily as a result, and more people were able to stay in their home or care setting if this was their wish.

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

- Not all volunteers and staff had the right safeguarding training at the right levels. Trustees had not received training in safeguarding adults, and most staff had not received training in safeguarding children. Although the service supports mainly adults, children visited the hospice daily and therefore staff should have been offered appropriate training.
- Not all areas used by patients had call bells so patients may not have been able to summon assistance if they fell or became unwell when alone in these areas.
- One of the organisation's risk registers was not reviewed in line with policy and had not been kept up to date.
- People's experiences, comments and suggestions were not being used in a methodical way to drive service improvements, and further work was needed to ensure that barriers were identified and removed for those who could potentially find it more difficult to access the service.

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, North.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Good 	Hospices for adults was the only activity provided at this location. The hospice had one inpatient unit providing specialised end of life care for 14 patients. Hospice at home services and day services were also delivered. We rated each of the five domains, safe, effective, caring, responsive and well-led as good.

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Background to The Rotherham Hospice

Rotherham Hospice is operated by Rotherham Hospice Trust. The service opened in 1996 and underwent significant expansion in 2011. It provides specialist end of life care for patients with a range of life-limiting conditions living in Rotherham and the surrounding area.

The hospice appeal was formed in 1988. Day patients were accepted following completion of the building in mid 1996, with an 8 bedded ward opening in 1997. Then part of the 8 bedded unit was refurbished in 2010 and a 10 bed extension opened in April 2011. The hospice now provides inpatient accommodation for up to 14 patients, day services for up to 75 patients per week, and care for 200-300 patients a month in their own homes.

It receives funding from a local Clinical Commissioning Group (CCG) and through charitable donations.

The hospice had a registered manager in post since 2011. At the time of the inspection, the registered manager had recently left the service. An interim registered manager had notified CQC that they had taken over the role temporarily. An application for full registered manager status was being processed.

At the previous inspection in August 2016, the provider was rated as requires improvement. The safe, responsive and well led domains were rated as requires improvement, with the other domains rated as good. At this inspection, we rated all five domains as good. Following this inspection, the hospice submitted action plans to demonstrate how they would be addressing the issues found during our inspection.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, a specialist medicines inspector and a specialist advisor with expertise in hospice care. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Information about The Rotherham Hospice

The hospice has one inpatient unit and is registered to provide the following regulated activities;

- Transport services, triage and medical advice provided remotely
- Accommodation for persons who require nursing or personal care
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

Up to 14 patients could be accommodated in the inpatient unit in separate, ensuite rooms. A day hospice service also operated three days a week. The hospice also offered exercise and relaxation classes, day therapies, and family support services which included adult and child bereavement support and counselling.

The hospice provided a hospice at home service split into two teams, a responsive team and planned team. Further community outreach included a domiciliary team, therapy services and outreach into care homes through the care homes project.

Rotherham Hospice had a board of trustees and four subcommittees that fed into this. Senior leadership was provided by the chief executive, inpatient unit manager and community service manager. A director of clinical services post was being advertised at the time of our inspection.

Summary of this inspection

During our inspection we visited the hospice and also patients in their homes. We spoke to 27 staff, including senior managers, registered nurses, health care support workers, doctors, therapy and domestic staff. We also spoke to two trustees and two volunteers.

We spoke to six patients or relatives about the care they had received. We looked at compliments and complaints received by the service as well as patient feedback surveys.

We observed care and treatment, and looked at 14 sets of patient notes and 10 medicines administration records.

Activity (February 2018 to January 2019)

- In the reporting period 2225 patients used the services of the hospice.
- All of these patients were adult patients. 20% were between the ages of 18 and 65, and 80% were over the age of 65.

Rotherham Hospice employed 53 registered nurses, 42 healthcare support workers and 69 other staff. The majority were employed on a part time basis. Doctors were employed by the local NHS trust who provided medical support through a service level agreement.

Track record on safety (February 2018 to January 2019)

- No never events
- No serious injuries
- 68 incidents where Duty of Candour was applied

There were no incidents of confirmed hospice acquired infections.

There was one formal complaint. It was not clear if this was upheld.

Services provided at the hospice under service level agreement:

- Medical services
- Hospice at home night time service
- Psychology service
- Chaplaincy Services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Our rating of safe improved. We rated it as **Good** because:

- Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to staff providing care. Care plans were person centred and recorded patients' needs, preferences and choices. This was an improvement on our previous inspection.
- The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time. This was an improvement on our previous inspection.
- The service provided mandatory training in key skills and made sure everyone completed it. Mandatory training was comprehensive and more than 90% of all staff groups completed it.
- Staff knew how to protect patients from abuse and worked well with other services to do so. They knew how to escalate any concerns to senior staff in line with the organisation's safeguarding policy.
- The service controlled risk of infection well. Staff kept themselves, equipment and premises clean. We saw staff observing 'bare below the elbows' guidance and using protective equipment appropriately. There was access to alcohol hand gel throughout the hospice for staff, patients and visitors to use.
- The service had suitable premises and equipment and looked after them well. The facilities manager had good oversight of all contracts relating to equipment checks and servicing, and made sure these were done on time.
- Staff completed and updated risk assessments for each patient. They knew how to recognise a deteriorating patient, kept clear records and asked for support when necessary.
- The service had enough nursing, care and medical staff with the right qualifications, skills, training and experience to keep people safe. Daily reviews meant that staffing could be increased or decreased according to the needs of patients.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and feedback.
- Staff collected safety information and shared it with teams. Managers used this to improve the service.

Summary of this inspection

However;

- The majority of staff had not been trained in children's safeguarding concerns. Only 7.7% of staff had received Level 1 Safeguarding Children training. There was a plan in place to train all staff by May 2019.
- Trustees had not received training in children's or adult safeguarding.

Are services effective?

Good

Our rating of effective stayed the same. We rated it as **Good** because:

- The service provided care and treatment based on national guidance and best practice. Staff followed National Institute of Health and Care Excellence guidelines for end of life pain relief.
- Staff gave patients enough food and drink to meet their needs and improve their health. Kitchen staff provided a comprehensive and varied menu and had received training on topics such as swallowing difficulties. The service had access to a dietitian who provided guidance and advice.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. Using a hospice dashboard, managers were clear where improvements needed to be made and what was working well.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. We saw staff used a range of pain assessment tools and adjusted medication accordingly. Patients in the community completed a symptom relief plan at the earliest opportunity with specialist nursing staff.
- The service made sure staff were competent for their roles. Staff had all received an appraisal in the previous 12 months. We saw that staff were given the time to complete nurse study days and the mandatory workbook. Nursing staff told us they felt well supported in their role.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. Every day, doctors attended both an inpatient and outpatient meeting. Care was joined up and resources could be allocated appropriately.
- Staff understood how and when to assess whether a patient had capacity to make decisions about their care. We saw in patient notes that their capacity was assessed on admission to the inpatient unit or when other signs indicated this was needed. Staff made appropriate decisions about deprivation of liberty safeguards and knew when to apply this.

Summary of this inspection

Are services caring?

Good

Our rating of caring stayed the same. We rated it as **Good** because:

- Staff cared for patients with compassion. Patients we spoke to told us that nothing was too much trouble for staff, and relatives felt their loved ones were treated well and with kindness. Staff demonstrated good communication skills and showed a caring and professional approach to their work.
- Staff provided emotional support to patients to minimise their distress. Bereavement support volunteers, listening volunteers and staff all contributed to help those in need of support. Patients told us they could ask any questions and were supported when upset.
- Feedback, thank you cards and regular questionnaires confirmed that patients and those close to them valued the services and emotional support offered by the hospice.
- Staff involved patients and those close to them in decisions about their care and treatment. It was clear from speaking to patients and staff, and from care records, that care and treatment was provided collaboratively. Patients or those close to them had significant control and input and their choices were respected where it was possible to do so.

Are services responsive?

Good

Our rating of responsive improved. We rated it as **Good** because:

- The service took account of patients' individual needs. Care plans were tailored to capture people's choices and preferences. These were comprehensive and person centred. This was an improvement on our previous inspection.
- The service planned and provided services in a way that met the needs of local people. Services were focussed on the needs of those using them, and there were strong links with local organisations. Patients and their families were routinely signposted to additional support.
- A voluntary chaplaincy service provided spiritual and emotional support for patients and a quiet room with multi-faith equipment was provided.
- People could access the service when they needed it. 85% of new patients were seen in the community within 24 hours, and the inpatient unit admitted and discharged patients seven days a week.

However;

- Although the service had only received one formal complaint in the last year, this was not investigated or responded to in line with policy.

Summary of this inspection

- There was a lack of insight or work around those who might be vulnerable because of their circumstances. There were no plans to identify or work with groups who might find it harder to access the hospice.

Are services well-led?

Good

Our rating of well-led improved. We rated it as **Good** because:

- Managers at all levels in the service had the right skills and abilities to run a service providing high quality, sustainable care. The service had visible and approachable leaders and trustees. Nursing leadership had been strengthened over the past 12 months and nursing staff spoke very highly of the changes made to support them. This was an improvement on our previous inspection.
- Managers across the service promoted a positive culture that supported and valued staff. Staff and volunteers told us that there had been a marked improvement in culture since key management appointments the previous year. Staff told us they felt more supported and positive about the future. We saw respectful interactions between staff and managers.
- The service used a systematic approach to continually improve quality and safeguard high standards of care. There were clear lines of accountability and staff knew what they were accountable for and who they reported to.
- 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 a clinical and corporate 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 engaged with patients, staff and the public. Views of staff were listened to and we saw some evidence of limited changes to services due to both staff and patient feedback. The hospice had good visibility in the local community and collaborated with partner agencies and other local hospices effectively.

However;

- Staff did not know and could not articulate the hospice values as these were being reviewed. New values were being developed collaboratively with staff and we saw evidence that the working ethos of staff would fit well with what leaders hoped to develop.

Summary of this inspection

- Feedback from people who use services and their families was not discussed at a high level and we did not see evidence that this was used consistently to change services.
- The service's clinical risk register was not reviewed in line with the risk management policy and was out of date.

Good

Hospice services for adults

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

Are hospice services for adults safe?

Good

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- Mandatory training was delivered both online and face to face. Staff received a mandatory training workbook to complete at their own pace, and their understanding was then tested online following completion. This consisted of 28 core modules, with an additional 10 for clinical staff.
- The workbook included topics such as fire safety, dementia awareness, information governance and mental health.
- Additional mandatory training was delivered both in house and in partnership with an external provider. For example, additional dementia awareness training was delivered face to face by an external provider.
- Information provided by the hospice showed that 96% of clinical qualified, 94.5% of clinical non-qualified and 92.6% of non clinical staff had completed the mandatory training workbook.
- The service was supported by volunteers to help with specific tasks. Volunteers did not undertake mandatory training but completed an induction process. We saw evidence in volunteer files of a structured induction, including familiarisation with the local working environment which was signed by the volunteer and their manager.

Safeguarding

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

- We saw that all staff and volunteers had received a Disclosure and Barring Service (DBS) check at the correct level for their role.
- The head of patient services was the service safeguarding lead. They had completed level three safeguarding adults training, as had the inpatient unit manager and other relevant key members of staff.
- Staff confirmed that they had received safeguarding training at a level relevant to their role and knew how to recognise abuse and neglect.
- The service safeguarding lead told us they met regularly with inpatient and community staff teams to discuss specific case studies and lessons learned. Staff confirmed that this was the case.
- The safeguarding policy was up to date and contained information relating to adults and children. We saw that topics such as female genital mutilation and child sexual exploitation were included. This was available on the hospice intranet.
- However, the hospice had not trained the majority of staff in safeguarding children . Only 7.7% of staff had received Level 1 Safeguarding Children training. We

would expect staff working with patients and families to hold Level 2 Safeguarding Children training. This had been identified by senior leaders as a gap in training knowledge, and plans were in place for all staff to receive children's safeguarding training at a level appropriate to their role by May 2019.

- Trustees had not received training in safeguarding adults or children. This was a potential risk to the service and not in line with the recommendations made in the Saville Enquiry Report of 2016.

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.

- Patient areas we visited were visibly clean including the reception / waiting area.
- Staff observed 'bare below the elbows' guidance and alcohol hand gel was available at each entrance to the unit. We saw staff washing their hands before providing care and treatment to patients. They had access to personal protective equipment such as gloves and aprons, and were seen to be using these appropriately.
- Audits from April to December 2018 showed that all staff (both in the hospice and in the community) were 96% compliant in meeting hand hygiene guidance.
- The service's clinical governance lead acted as infection control champion. They arranged quarterly inspections of the hospice environment by infection control specialist nurses from the local NHS trust. Outcomes were shared at governance meetings and learning actioned appropriately.
- We checked monthly, weekly and daily cleaning schedules and associated audits, which showed that all areas of the service were cleaned as required.
- We saw staff used green 'I am clean' labels to identify equipment which had been cleaned and the date this was last completed.
- Patients remained in individual side rooms following their death. Cooling equipment was used to preserve the deceased person's body where needed. Links were in place with local undertakers who removed bodies straight from rooms. Staff told us how they controlled access to the area when this was taking place in order to avoid distress to other people in the unit.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

- The hospice was on two floors and there was an accessible lift, which was regularly serviced. The inpatient unit could be accessed from the ground floor so that patients arriving on stretchers could be accommodated. Accessible toilets were available for patients, staff and families.
- The inpatient unit was not locked. Visitors signed in at reception during the day, or could be buzzed into the unit by staff at night. The hospice had an open visiting policy which meant that people could arrive at any hour, and staff checked that they were appropriate visitors if arriving overnight before allowing them into the unit. CCTV around the hospice meant that staff could see anyone wishing to gain access.
- The facilities manager had oversight of all facilities, premises and maintenance issues. Reports, inspections and audits were available to staff online. The sites and facilities team met every two months to discuss any issues, and those requiring decisions with a financial implication were escalated to the senior management team monthly meeting and board as appropriate.
- Records showed that electrical equipment was serviced and safety tested to ensure it was safe for use. An external company provided clinical equipment compliance checks including water checks and Legionella testing.
- A log of all substances meeting the Control of Substances Hazardous to Health Regulations (COSHH) was held centrally by managers of domestic staff. Members of the cleaning team reviewed the log and details of each substance and signed to say they had noted the contents.
- A fire safety and evacuation procedure was displayed in reception, and staff knew the procedure to follow in

the event of fire. Staff confirmed that a full fire drill had been conducted in the previous six months and feedback on performance had been provided. Fire extinguishers were checked on a weekly basis.

- Syringe pumps were maintained and used in accordance with professional recommendations. We saw evidence that staff checked these regularly. In the community, syringe pumps were normally monitored by district nursing staff not employed by the hospice. We saw good communication between hospice specialists and this team, and patients using syringe pumps were discussed at hospice at home handovers daily. The specialist team managed those patients using the devices with more complex needs.
- Resuscitation and emergency equipment was available onsite and easily accessible. Checks on resuscitation equipment were up to date. 73% of staff had completed basic life support training in the previous 12 months.
- Bariatric patients could be accommodated and the hospice had recently rented an additional bed to meet this group of patients' needs.
- The service stored medical gases in line with the manufacturer's best practice guidelines.
- Patients requiring equipment in the community were able to access this in a timely manner. Initial assessments were carried out by hospice at home staff who agreed with the patient what their needs were and could then action this. The hospice had its own drivers who could complete delivery of equipment when needed.
- However, we saw that on our first visit to the area, a door to the main treatment room was propped open, providing easy access to equipment such as needles. This was immediately brought to the attention of senior staff. We checked twice more during the course of the inspection and found the door locked with a keypad.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

- We reviewed ten sets of patient notes, those of six inpatients, and four patients living at home. All included care plans and risk assessments. Families and patients knew what the plans were for their ongoing care. Risk assessments were revisited weekly with an option to do this more frequently as needed.
- Staff knew how to recognise a deteriorating patient and how to escalate this. We observed nursing staff asking doctors to review a patient who became more poorly and saw that doctors reviewed patients promptly when asked to do so.
- Inpatient records included; an integrated nursing and medical assessment, mental capacity assessment, do not attempt cardiopulmonary resuscitation form if appropriate, and Waterlow (pressure sores) and MUST (malnutrition) assessments. Patients were also assessed for their risk of falls, had a full cognitive assessment, and if bedrails were used this was clearly documented. There were review dates for all assessments, which were all dated and signed.
- Care plans were individualised to cover the psychological as well as physical needs of patients. Where a patient had changing needs, for example, becoming increasingly agitated due to their condition, staff adapted their care plan accordingly.The daily multi disciplinary team (MDT) meeting provided an opportunity for further review and amendment.
- Staff could access more senior review 24 hours a day. The hospice 24 hour advice line was staffed by nurse specialists who could call on doctors and consultants to provide specialist input as needed.
- Risk was identified in the community by clinical nurse specialists as part of the hospice at home service. Each patient receiving the service was assessed for their falls risk, moving and handling, and management of pressure areas. These were reviewed weekly or more frequently if needed.
- Each inpatient was reviewed on a daily basis by clinical and non-clinical staff for example doctors, physiotherapists and nurses. We saw that discussions took into account changing needs such as tolerance of particular formulas of drugs.

Nurse staffing

Good

Hospice services for adults

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

- A total of 53 nurses were employed by the hospice, 27 working full time and 26 part time.
- Nurse and care staffing levels were calculated each morning by a senior nurse using a dependency tool to assess each patient's individual needs. If the dependency tool scored above a certain level, additional staffing would be arranged for that day. We spoke to staff who told us that in their experience, the tool worked well and triggered the need for additional resource appropriately.
- The service did not use agency staff unless in very unusual circumstances and had a strong bank of staff, largely their own part time team, who filled in as needed. The service provided mandatory training to bank staff who were supernumerary for three shifts prior to their competency to work unsupervised being signed off.
- Any incidents were cross checked against the dependency tool to ensure the model was still providing the correct indicators. There were no nurse vacancies at the time of our inspection, however sickness rates for clinical staff were 10%.
- Three student nurses also supported the service on placement, the hospice also employed two apprentice health care support workers, and volunteers were used widely. For example, listening volunteers sat with patients in the inpatient unit to provide company and talk or read to them. A volunteer co-ordinator provided suitable inductions and background checks.
- Patient care was also supported by a wider team including healthcare assistants, therapists and domestic staff.
- Nursing staff told us that they felt staffing levels were appropriate, and they had time to give compassionate care.

Medical staffing

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

- The service had access to two consultants on call 24 hours a day, plus two specialist doctors. A GP registrar trainee attended three days a week. Doctor cover was available onsite between 9am and 7pm weekdays and 9am and 5pm at weekends. There was also an on call medical rota outside these hours. Calls made to the 24 hour hospice advice line were triaged and consultants could call back if needed. Medical line management was provided by the medical director at the local NHS trust who employed the medical staff working at the hospice.
- We saw from rotas that the planned medical staffing skill mix matched actual staffing levels, and flexed to meet patient need. Medical staff attended the MDT catch up meeting every day. The team provided palliative care support not just for the hospice but also the community and local hospital, meaning that there was good, joined up communication and planning to meet patient needs. The medical team met with the service chief executive on a monthly basis.

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 looked at ten sets of patient records, four community patients and six from the inpatient unit. We saw that consent to share information with relevant people had been correctly obtained and recorded.
- 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. People were asked how they liked to be addressed, and who was important to them. Staff completed care plans appropriately and we saw that they recorded when care was carried out in line with the care plan.

- We saw patient records were stored securely in an area only accessible to staff. Staff completed care plans and records in this area, where they could not be seen by people who did not have the right to access the records.
- Records included an integrated nursing and medical assessment, completed on admission. Patients' cognitive function, risk of falls, eyesight, continence, pressure areas and current medication were all reviewed when they were admitted and recorded as part of their care plan.
- 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 detailed the patient's needs and preferences and took account of any additional needs such as dementia and behavioural needs.
- The service audited inpatient and day patient records once a month, including elements such as fully completed risk assessments, person-centred care planning and entries that were consistently signed and dated. Community records were audited on discharge. From September to December 2018, the service was between 95.5% and 100% compliant with these audits.
- The hospice had access to an electronic records system used across the community and in primary care. Staff could use this to see at a glance what other providers' recent input into any patient's care had been.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

- A CQC medicines inspector looked at how medicines were managed. We checked the medication administration records (MAR) for four patients and personal care files for four patients. We checked storage conditions and the recording of controlled drugs.
- The hospice had a detailed medicines management policy which was regularly reviewed, understood by relevant staff and specific to this service. Prescribers had access to local, regional and national prescribing guidelines relating to medicines used in the hospice. We saw that nurse prescribers received regular supervision sessions from doctors.
- Community nurse prescribers carried emergency medication with the relevant Patient Group Direction (PGD) in place.
- Medicines were supplied to the hospice by a private pharmaceutical provider. Discharge medication was provided by the local hospital. Staff recorded all deliveries of medicine and this was countersigned by a doctor. We checked a sample of medicines, both the patients' own and those in stock, and found that all were in date, and correctly and securely stored.
- A pharmacist visited the hospice weekly to review medicine charts, develop quality assurance procedures for medicines and train staff. The hospice also had access to an on-call pharmacist 24 hours a day when needed.
- We checked four sets of medication administration records and found that in all cases where applicable, people's allergies were clearly documented. We saw that these patients received their medicines as prescribed. When medicines were to be administered at variable doses, nurses had recorded how much and when these were given. Where medicines were being given over a longer time, such as patches or infusions, staff regularly checked these were still working until the next dose was due.
- Controlled drugs were recorded in a separate book. This was correctly and fully completed. When controlled drugs needed to be destroyed, this was recorded separately and destruction was witnessed by a pharmacist accompanied by a nurse or other senior staff member.
- During our last inspection we found that medicines with a shortened expiry date once opened did not always have the date that they were opened appropriately recorded. At this inspection we found that this date was always recorded and the medicine labelled clearly with the patient's name and dose.
- Fridge temperatures were checked and recorded daily. These were within an appropriate range, and staff

knew what to do if this was not found to be the case. There was air conditioning in the room where drugs were kept and this temperature was also monitored daily.

- We observed a medicine round and saw that staff wore red 'do not disturb' aprons. Staff followed processes in line with the medicines management policy. Patients' symptom control needs such as pain, nausea and vomiting were assessed by staff during the medicines round.
- Patients who were being discharged were given thorough verbal information about their medicines by nursing staff, and given leaflets to reinforce this message.
- The service conducted monthly audits of prescribing trends, errors and a twice yearly review of practices against controlled drugs standard operating procedures. The service was 98% compliant at the most recent controlled drugs audit.

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.

- The hospice had not reported any serious incidents or never events in the previous 12 months. Never events are serious, preventable patient safety incidents which should not occur if preventative measures are in place.
- Incidents were reported using a paper-based system. Staff knew how to report incidents and were encouraged to do so. We checked incident investigations, and saw root cause analysis (RCA) had taken place, which highlighted lessons learned and contributing factors. RCA is a method of problem solving that tries to identify the root cause of an incident. When incidents do happen, it is important that lessons are learned to prevent the same thing happening again.
- Learning from incidents was cascaded at team meetings by heads of department. National Patient Safety Alerts were disseminated through the senior leadership team to heads of department for discussion at team meetings.
- The hospice incident management policy was in date and had been ratified by the board in the last 18 months. The policy gave clear guidelines about the process for reporting and categorising incidents, and encouraged an open culture of incident reporting.
- Senior managers were reviewing incident investigation and management at the time of our inspection with a view to improving processes. Previously, incident investigation had been centrally owned within the executive team. The new chief executive was working to encourage greater ownership of incident management throughout the organisation by providing heads of departments with the skills and tools to own and investigate incidents at a more local level, so that those involved benefitted more directly from the investigation and learning process.
- Duty of Candour (DOC) is a regulatory duty that relates to openness and transparency. It 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 organisation had 68 incidents where DOC applied between February 2018 and January 2019. We saw evidence that this had been applied and letters had been sent to relatives of a deceased patient offering further support.
- Staff spoke about duty of candour and understood the need to be open and honest with families when things went wrong. They knew when DOC would apply and how to record this.

Safety Thermometer (or equivalent)

Staff collected safety information and shared it with teams. Managers used this to improve the service.

- The organisation collected data on falls, pressure sores and catheter associated urinary tract infections regularly. This data was reviewed by heads of department and brought to the clinical governance group. Reporting was completed monthly throughout the year.

Good

Hospice services for adults

- During the inspection the service provided information on the number of falls and pressure ulcers from April 2018 to December 2018. Two patients had developed pressure sores, and 27 patients had been admitted with a pressure sore and received appropriate care and treatment for this.
- There had been 25 falls over the same period, 14 causing no harm, 10 low harm and one moderate harm.

Are hospice services for adults effective? (for example, treatment is effective)

Good

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.

- 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.
- Care planning was implemented as early as possible and plans were identical in both the inpatient and community settings and transferred between the two. Patients confirmed that plans were delivered in line with their wishes. Care planning included discussion about support for the patient's family and we saw evidence of families and friends being emotionally, and practically helped to support the person using the service.
- The hospice had improved its early identification of preferred place of death for their patients and were actively reducing admissions when a patient indicated they would prefer to stay at home.
- The chief executive was working with other local hospices to develop joint working pathways and share best practice working with the Yorkshire and Humber Hospice Network. The head of patient governance attended regional meetings on topics such as best practice in medication to share and disseminate information to staff. Team doctors attended the national palliative care conference to keep up to date with best practice.

Nutrition and hydration

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

- Staff used the malnutrition universal screening tool (MUST) to assess the food and drink needs of patients. These were completed in all six of the inpatient records we looked at. Staff discussed the nutritional needs of each patient during the morning multidisciplinary team meeting and suggested amendments as needed. The head of the inpatient unit then fed this back directly to catering staff.
- The service had access to a dietitian based at the local NHS hospital trust who visited once a week. They had provided training to kitchen staff on topics including dysphagia (swallowing difficulties) and allergies. Dietitians were available to give telephone advice as needed during normal working hours and would come to review any patients with particularly complex needs as necessary.
- Kitchen staff provided a menu including hot and cold food options, soups, sandwiches and desserts. They had received training and could provide liquidised or soft diet options and could cater for specific needs

such as vegan, gluten free or halal. The menu rotated every three weeks. Managers were proactive in encouraging kitchen staff to develop their own menus and try new things. Hospitality training was also provided to those volunteers who helped to serve food.

- Staff would prepare food that was 'off menu' if that was a patient's preference. Patients told us that they enjoyed the food and had constant access to food and drinks. If a patient was admitted at night, nursing staff had access to dried and tinned food, cereals and toast to enable them to provide something for new patients to eat. Families were encouraged to help at mealtimes and had the opportunity to bring in patients' favourite food and drink.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

- Staff assessed patients in the inpatient unit regularly and we saw that they discussed patients' levels of pain or pain symptoms with them. Nursing staff also checked on patients during medicine rounds, and other voluntary and domestic visitors to the bays were mindful that patients could be in pain and knew to ask a nurse to review the patient if this seemed to be the case.
- Staff could access different pain assessment tools including those suitable for people who were not able to verbalise their pain. We saw in patient records that pain assessment tools were completed well and pain was controlled promptly.
- We saw that staff documented in patient notes when pain was present and adjusted pain medication accordingly. At a morning MDT meeting, we saw that all patients' pain and symptom control were discussed as standard and plans were made to adjust these as needed.
- We observed a member of the community nursing team assessing a new patient. As part of a comprehensive review, they discussed a pain management and symptom relief plan with the patient which was signed by both parties.
- The service was conducting an ongoing audit to assess the effectiveness of non-pharmacological interventions to support symptom management (acupuncture and complementary therapies).

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them.

- Managers produced a dashboard on a monthly basis so senior leaders could see progress against a number of indicators. We saw, for example, that the service's care homes project was exceeding targets for preventing unnecessary GP appointments (87 appointments saved in March 2019 against a target of 50) and responsive early discharges (nine in March 2019 against a target of five).
- The team used a 'red amber green' (RAG) rating system to show when metrics fell below planned monthly levels.
- The service produced a yearly audit plan, covering topics such as data quality, NHS safety thermometer, internal records and medicines management. We saw that all plans for audits were up to date and audits were being completed on time.
- The local clinical commissioning group (CCG) met regularly with the hospice to discuss contract monitoring. However, contract monitoring, a yearly audit programme and the hospice dashboard did not seek to understand the 'softer' outcomes for patients such as how effectively they were supported to maintain emotional wellbeing or how well their cultural or spiritual needs were met.
- Community leads had jointly audited palliative care in the community with the palliative care lead in the local district nursing team in March 2019. Together they reviewed notes of patients cared for by both teams, including auditing the completion of do not attempt cardiopulmonary resuscitation forms. As a

result of this audit, actions were identified for both teams including some joint learning opportunities and it was agreed to revisit the exercise on a three monthly basis.

Competent staff

The service made sure that staff were competent for their roles. Staff had the skills, knowledge and experience to support patients. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

- We reviewed ten personnel files from a variety of clinical and non-clinical staff and volunteers. We saw that in all cases, they had received a formal appraisal in the previous 12 months.
- All nursing staff files showed that their registration had been checked with the nursing and midwifery council. Registered nurses and health care support workers had completed additional role or skill specific training, for example on syringe driver usage, medicines management, nausea and vomiting, and the role of the funeral director.
- Planned or recently completed nurse study days included tissue viability training, cancer and mental health, and breaking bad news.
- Staff attended informal sessions led by doctors, which were open to anyone to attend. They provided a forum whereby staff could discuss the emotional and social aspects of providing end of life care.
- Basic training on autism, dementia, mental health and people with a learning disability was provided to all staff through the hospice mandatory training workbook. We saw that nursing staff had also undertaken study days on these topics. Clinical support workers received training on specialist palliative topics from Macmillan.
- Volunteers were assessed to ensure they had the correct skills and competencies for their role and were provided with a thorough induction. We saw from volunteer personnel files that induction checklists were used and signed by volunteers to show they were happy with their induction.
- Nursing staff told us they felt very well supported and competent to fulfil their role. A relatively new starter explained they had had a mentor when they first started which helped with their learning.

Multidisciplinary working

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

- There were daily multidisciplinary team meetings, one for the inpatient unit and one for the hospice at home service. These were attended by nursing staff, doctors, health care assistants, therapy and administration staff.
- We observed two daily multidisciplinary team meetings and saw positive working relationships between all staff. We saw that the care and treatment of every patient was discussed at the meeting and a management plan put in place.
- Nursing staff, including bank nurses, told us that doctors were approachable and part of the team. They told us they never felt 'spoken down to'. Doctors told us they supported the nurses to do their job and felt proud to be a part of the team. Health care support workers told us they felt able to contribute actively to the team.
- Work with local care homes had provided a further link into the local community and had led to improved multi disciplinary working across the local area. Staff provided bespoke help and advice to care home staff which had been shown to reduce unwanted visits to hospital and enabled patients to stay in the community for longer if that was their wish.
- As the same team provided end of life care across the local NHS trust, at home and the hospice, the service had effective links into local services including mental health and other community services.
- The local neurological multi-disciplinary meeting was held at the hospice rather than the local hospital which provided good links with advanced care practitioners working in the community.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

- Staff identified people who could benefit from extra support and discussed changes to care and treatment with patients and those close to them. Staff supported people to maintain their own health and wellbeing.
- We observed an exercise group overseen by a physiotherapist as part of the day hospice service. Patients were fully engaged in the activity and we heard that patients valued the social and emotional support that this service provided.
- Leaflets were available in the hospice on topics such as living positively with cancer, managing breathlessness, and Macmillan services.
- Staff were able to refer patients to Rotherham social prescribing service, who provided help and support with issues such as lifestyle changes, looking after yourself, managing symptoms, money and positive thinking.

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) is designed to protect patients who may lack capacity, to make certain decisions about their care and treatment. 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 six inpatient records and saw that in all cases, mental capacity assessments had been carried out appropriately at the time of admission. In all six records we saw that DoLS was considered and the decision as to whether to apply this or not was clearly noted. Where patients had a change in their capacity or staff had any concerns about this, a reassessment was conducted.
- We saw that do not attempt cardiopulmonary resuscitation forms (DNACPR) were correctly and fully completed where appropriate for that patient.
- If a patient's condition required the use of bed rails, consent was signed either by the patient or someone with lasting power of attorney before these were put in place. Patients were therefore not deprived of their liberty by being restrained in bed without their consent.
- The service's mandatory workbook provided all staff with training in the five principles of the mental capacity act, assessing capacity, and deprivation of liberty. Nursing staff received additional face to face training on the mental capacity act.

Are hospice services for adults 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 those close to them confirmed that staff treated them well and with kindness.

- Patients we spoke with told us that staff were very caring and took time to check on them regularly. One patient told us that 'nothing was too much trouble' and they were able to ask questions whenever they wanted.
- Relatives and friends told us that their loved ones were receiving 'fantastic care' and that staff could not do enough not just for the patients, but for them too.
- We saw that patients in the community received good quality, person centred care from supportive, knowledgeable staff.
- Staff protected patients' privacy and dignity when providing care and treatment, and this was confirmed

by patients. We saw doors being closed when providing personal care or treatment, and staff respected 'do not disturb' signs and encouraged visitors and volunteers to do the same.

- Patients told us that staff responded promptly if they were in pain or distress. They said that call bells were answered quickly and staff went out of their way to help them. During our visit to the unit, we found that staff and volunteers checked so regularly on patients that call bells were hardly ever used.
- Feedback and thank you cards were displayed prominently around the hospice. We saw multiple examples of cards from universally thankful friends and families who praised the care given by staff to their relatives.
- Domestic staff were an integral part of the team and took the time to speak with and sit with patients when they had the time to do so. Nurses and managers spoke positively about the interactions between domestic staff and patients and how they formed a regular positive part of most patients' day.
- After the death of a patient, those close to them were able to spend time with them in their room. When someone had recently died, a candle was lit near the nurses station on the ward. All staff and volunteers were aware of the meaning of the candle and were particularly mindful of their behaviours and that of other patients and visitors.
- People remained in their rooms after death until leaving in the care of the funeral director. Staff explained how this could be done with dignity and respect, while ensuring that other patients and visitors did not witness the body leaving the hospice.

Emotional support

Staff provided emotional support to patients to minimise their distress.

- Staff supported patients well and we saw they were communicating sensitively and thoroughly with patients and those close to them. Patients told us they could ask any questions and they were given support when they were upset. Listening volunteers worked in the inpatient unit to sit and speak, read to, or just listen to patients.
- We saw that at morning MDT meetings, it was discussed which patients were feeling more emotionally vulnerable that day. One person was described as 'fed up' and no longer wanted to get out of bed. It was arranged that they would have a listening volunteer to sit with them that day to explore their concerns and see if a chat would help them.
- The head of patient and family support services oversaw bereavement support volunteers helping people who had been bereaved. Evaluation of this service was very positive, with over 90% of families or friends finding this useful. The volunteers received monthly support through group supervision.
- The hospice provided bereavement support for children and teenagers through the Sunbeams group. The group met twice weekly and children attended up to 8 sessions. The group enabled children and young people to explore death and grief in a supportive, therapeutic environment. The counsellors had links to the Primary Care team and Child and Adolescent Mental health service.
- One bereavement support group met in the community room in a local supermarket. This enabled families or friends of people who had passed away to speak about their loss without the potential for further upset caused by returning to the hospice.
- We heard that bereavement support volunteers sometimes attended patient funerals to support families. For those patients or relatives with acute anxiety, a referral for complementary therapy was available.
- A range of children's books on the topics of grief and loss were available in the quiet room for families to access.
- The hospice worked closely with local voluntary agencies including those providing carer assessment and support. The 24 hour hospice support line signposted families, care homes, district nurses and other professionals to community and statutory services.

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.

Good

Hospice services for adults

- Relatives and those close to patients were actively involved in the care and treatment of their loved ones. Open visiting times meant that they could visit whenever they wished and fold up beds were provided for people who wanted to stay overnight. Low cost, good quality food and drink was provided by the hospice café.
- We spoke to a relative visiting a patient who told us that the patient had been transferred from hospital and was more settled in the hospice. The patient and relative were in one of the several break out areas in the inpatient unit, watching television together. The patient told us that since their pain relief had been more effectively controlled they felt much better. They had had their hair styled in the hairdressers at the other end of the hospice earlier in the day and felt they were treated 'as a proper person'.
- We saw evidence in patient records that care plans were developed collaboratively with patients and families. Relatives were encouraged to help to feed patients at mealtimes if this was appropriate, and could bring in special foods, treats or alcohol for patients.

Are hospice services for adults responsive to people's needs?
(for example, to feedback?)

Good

Our rating of responsive improved. 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.

- Translation services were available both in the community and inpatient unit, through the telephone system used by the local trust. Telephone numbers were visible in the inpatient unit and staff knew how to access the service. However there were no visible posters or signs to inform patients, their families or friends that this service was available.
- A quiet room was provided for patients and those visiting to use for prayer and reflection. Prayer mats, a Torah and other multi-faith equipment was provided for use in this room.
- There were good links with a local social prescribing scheme, nursing and care homes, funeral directors, and fire services. Community welcome packs left in patients' homes following an initial visit included support for carers and links to carers cafes.
- The hospice provided a blood and iron transfusion service which enabled people to receive treatment without attending hospital. However, we saw from the hospice dashboard and minutes of the senior leadership team that this service was not well used as there was a reduction in the number of blood transfusions that were prescribed due to changes in clinical practice. Work was ongoing to revitalise the service by increasing the number of iron infusions provided at the hospice in line with clinical guidance.
- Nurses told us that they could easily access other parts of the organisation to arrange services for patients. For example, the family support team could provide psychological support or help to apply for financial support. Staff from the hospice at home team told us they had accessed one of the hospice shops to provide bedding and a new mattress for a family who had nothing for a patient to sleep on.

Meeting people's individual needs

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

- Care plans were in place for inpatients, patients in the community and day-care patients. These were person centred and we could see that people and their carers had had the chance to discuss them and contribute. Care plans were signed by the patient and / or their main carer. This was an improvement on our previous inspection.
- We observed a nurse specialist making an introductory visit to a patient. We found the nurse was very respectful of being in the patient's home, and gave a full overview of services available including day-care, hairdressing and the inpatient unit. They

developed a plan of care collaboratively with the patient. A very comprehensive assessment of symptoms was conducted and good advice was given. The nurse obtained a clear picture of the patient's family and wider support network and assessed their spiritual needs. The completed personalised plan was left with the patient, along with details of the 24 hour hotline if the patient needed support. This assessment and interaction was a skilled assessment, conducted by an experienced nurse specialist who demonstrated a passion for their role.

- A 24 hour helpline was available to people wishing to seek further advice if their condition deteriorated. This was supported by clinically trained staff with access to consultant level input as needed.
- Transitions from children to adult services were rare, but we saw staff were in discussion with another provider about managing this process for one person, and had begun to plan jointly with them for a smooth transition to the adult service.
- The hospice had access to voluntary chaplains who visited the service twice a week. There were plans to refine this service, which, at the time of our inspection was provided on an ad-hoc basis with no targeted visits or referral system for the chaplains.
- People were encouraged to ask their own faith leader to visit if they had one, and the hospice had links with the local hospital chaplaincy team who could signpost to a specific faith if requested.
- There was a quiet room available for patients and families to use for prayer or contemplation. However, this room did not have a call bell which meant that if a patient was left to reflect alone they could be unable to call for help.
- The hospice was able to make reasonable adjustments for people with a disability. Training and support was available so staff were clear how to support someone with a learning or physical disability.
- However, there was a lack of insight or work taking place around those who may be vulnerable because of their circumstances. There was no regular patient or public involvement group or strategy, and there had not been any work with people or groups with protected characteristics within the past year.
- The board were not representative of their local community. One of the trustees told us that 'there aren't really any homeless in Rotherham'. There seemed to be a lack of insight at board level of the potentially unmet needs of the wider and marginalised population and no plans to address this.

Access and flow

People could access the service when they needed it. Arrangements to admit and treat patients were in line with good practice.

- The hospice accepted referrals to the inpatient unit from the 24 hour helpline, GPs, district nurses and the local hospital. The inpatient unit did not normally have free beds. Patients were prioritised for admission on the basis of their clinical need. The unit received admissions and discharged patients seven days a week.
- Managers used an escalation tool to assess the level of demand and activity in the inpatient unit. This was completed at the beginning of every shift. Extra staff were brought in if necessary to meet the needs of patients.
- New patients in the community were triaged, and referred to be seen for an initial visit within 24 hours. On average, 85% were seen within this timescale, and a further 10% were assessed as not needing a visit, either because they had passed away, been admitted to the hospital or hospice, or had asked not to receive a visit.
- Referrals to the service were managed well. The hospice at home team worked to keep people at home if that was where they wanted to be. A referral to the inpatient unit did not therefore always result in admission. People's preferences were respected and met where possible.
- As the hospice managed patient care both in their own homes and in the inpatient unit, it could be very responsive to people's needs and staff were able to admit or discharge patients at short notice.
- The team met daily to discuss patients across the inpatient unit, those in hospital and those in the

community. As the medical staff provided support across all three areas, they were well placed to decide what movement needed to take place that day and what resources could be allocated to support this.

- The hospice offered day-care on a 12 week rolling programme. However staff told us that there was no particular emphasis on discharge from day-care and that some patients had been with the service for far longer than this. We looked at four sets of day-care patient notes and saw there was no real goal setting or discharge planning for these patients. Senior staff told us that a review of the day-care service was planned.

Learning from complaints and concerns

- 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. Patients and relatives we spoke to told us they knew how to make a complaint and would be confident to do so if necessary. All patients received an information booklet on first assessment by the service which included a section on how to raise concerns.
- The service received one formal complaint between February 2018 and January 2019. We reviewed details of this complaint and saw that this was not handled in line with the complaints policy and was not resolved by the service's 28 day target. Senior leaders were aware that feedback mechanisms, including complaints, was an area that could be strengthened.
- We reviewed a second, informal complaint and found that this was well handled, however, there was some blurring of lines between the complaints process and other HR issues as a copy of the outcome of a disciplinary hearing was sent to a staff member as part of this process.
- The lead for complaints and patient experience was aware that the number of formal and informal concerns was low and was beginning to work on how to encourage more feedback of all kinds.
- We saw that compliments thanking individual staff were passed on to those concerned. A copy of the letter to staff containing details of the feedback received was placed in their personnel file.
- The service received 346 compliments between February 2018 and January 2019.

Are hospice services for adults 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 hospice was overseen by a board of trustees led by the chair. The senior leadership team was made up of the chief executive, an inpatient unit manager and community service manager who managed the service on a day to day basis. The director of clinical services post was vacant and the role was being covered by the chief executive whilst recruitment was underway. Both trustees and senior leaders spoke positively about their working relationships and felt that this provided effective working.
- Nursing leadership was provided by the chief executive and the inpatient unit manager. The chief executive was a registered nurse who had a standing invite to attend the clinical governance subcommittee. Nurses could not speak highly enough about both leaders, who were relatively new in post, describing them as 'the right people for the job' and very approachable.
- Senior leaders were visible and approachable. We saw positive relationships between staff and leaders. Trustees regularly visited specific areas of the hospice and fed back to staff on their visit. This was discussed at board level and staff were encouraged to have their say on findings.
- The service was sighted on the need to strengthen the trustee cohort to provide a wider skill mix. Retiring

trustees spoke positively about recent changes in senior leadership and felt that the hospice had made significant progress, particularly in the previous six months.

- 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 pay, terms and conditions.

Vision and strategy

- The service was in the process of reviewing its vision and values collaboratively with staff. As a result, staff were not able to articulate the service's current vision. However, we saw that the working ethos of staff fitted well with what leaders told us they hoped to develop.
- The hospice's 2018-2021 Strategic Plan included strategic objectives around sustainability and clearly indicated the direction of travel for the service. Underpinned by a service development and improvement plan, the document demonstrated that the hospice had a good sense of its current position and strengths and weaknesses, and had addressed what it needed to do to take things forward. However we did not see any evidence of patient or wider public consultation in the production of this document.
- The senior leadership team had produced a moving forward and working better together document to capture the distance travelled in terms of change from later 2018 onwards, and what still needed to change in the forthcoming year. This had been collaboratively produced with staff feeding into what needed to stop, start and continue. Each objective had a named person or group of people responsible for delivery and clear timescales for completion.
- The service had workable plans to manage recruitment of staff. The inpatient unit offered placements to student nurses and GPs on rotation.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

- Staff and volunteers we spoke with told us that there had been a marked improvement in culture since the arrival of the chief executive the previous year. The subsequent addition of a new head of the inpatient unit had further improved morale and we saw and heard staff display positive and supportive relationships. One member of staff explained that they had previously experienced what they described as blame following an error. Since the arrival of the chief executive and inpatient unit manager, they had felt supported, and explained that errors, which remained rare, were now seen as a chance for learning and reflection and they felt supported rather than punished.
- Staff told us they 'wouldn't work anywhere else' and were proud to support the people who used services. We saw that the culture was firmly focussed on the needs of people.
- We saw evidence that when staff behaviours were not in line with the hospice values and ethos, appropriate action was taken.
- The service had a whistleblowing policy which was available to all staff and information on how to raise whistleblowing concerns formed part of mandatory training. Staff we spoke to knew how to raise concerns.
- The equality and diversity of staff was respected. People's protected characteristics were recorded in their staff files and we saw evidence that when one member of staff's physical needs changed, a risk assessment was conducted and adjustments made accordingly.
- Teams worked collaboratively and we saw examples of positive cross-team working to provide joined up care for patients. There were particularly strong links between those working in the community and inpatient staff, meaning that patients received a seamless service.
- The service had an in date lone working policy. Staff and volunteers working in the community had a buddy system with another worker who would call if they were not where they were supposed to be on time. Staff wore personal safety devices when entering people's homes and could call for assistance using these discretely if needed.
- On the second day of our inspection, a staff wellbeing taster day was underway, with external speakers and providers offering advice and support to staff on a

range of topics promoting their own health and wellbeing. Staff we spoke to appreciated the investment in them, including an hour out of their working day to attend. They told us it was part of an improving picture, boosting their morale and making them feel more valued as a workforce.

Governance

The service used a systematic approach to continually improve quality and safeguard high standards of care.

- 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 reviewed minutes of the clinical governance sub-committee and interviewed the recently retired chair of the committee. We saw that the group was normally attended by three trustees and members of senior staff. Compliance, quality and safety issues were discussed, including a review of the hospice quarterly performance dashboard.
- Each subcommittee met quarterly and presented a report to the full board meeting. Senior managers and trustees told us that they felt effective challenge was offered at these meetings. Trustees told us they felt the quality of information and the communication between themselves and senior operational leaders had improved since our previous inspection.
- However, we did not see any evidence that feedback from people who use services and their families was regularly discussed at board or sub-committee level, or that change was consistently patient and family driven.

Managing risks, issues and performance

The service had systems to identify risks, plan to eliminate or reduce them, and cope with the expected and unexpected.

- Senior leaders and managers had a good awareness of risks and performance issues and had identified and carried out action to address this. For example, the chief executive identified soon after entering their post that safeguarding children training was not being completed by all staff and put plans in place to rectify this by May 2019.
- The hospice's managing risk policy was ratified in February 2019. We reviewed the policy and found it to be comprehensive and the contents appropriate.
- The hospice's corporate risk register was managed by the chief executive and the board had oversight and input into the contents. This was up to date. Board members were able to tell us what some of the biggest risks for the service were, so we were assured that there was good oversight of this register.
- The hospice had plans to ensure continuity of care in an emergency. We reviewed the business continuity management policy 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 in the process of being reviewed.
- However, the service's clinical risk register was not reviewed in line with the risk management policy. In 2018, the risk register was reviewed twice, in January and July. It was not reviewed at either the April or October meetings as suggested by the organisation's policy. All entries on the clinical risk register were due for review in quarter four of 2018-2019. We were not provided with any minutes of this committee from 2019. We therefore did not have assurance that the clinical risk register was reviewed regularly.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

- Policies and procedures were stored and available electronically on the service's shared drive. Important information such as safety updates and performance issues were shared in team meetings and handovers.
- The hospice's records management policy was in date and clearly set out roles and responsibilities including those of the Caldicott guardian and senior information risk owner.

- Paper records were stored securely and record retention schedules for both these and electronic records were in line with policy.
- The service met weekly with commissioners to share information and complied with quarterly monitoring requirements. The Hospice's records management policy was in date and contained relevant and updated links to national guidance.
- Trustees also carried out informal inspections of services which enabled them to identify performance issues and areas of concern and gave staff an opportunity to raise issues directly with them. These inspection reports and staff responses and action plans were discussed regularly at board level.
- All staff received information governance training as part of their mandatory induction.

Engagement

The service engaged 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 support patients' needs. Local care homes used the 24 hour helpline extensively and the local NHS hospital trust worked collaboratively with the team to support patients.
- The views of staff were fed through to senior leaders. Staff we spoke with said that the recent move towards a more reflective culture had meant they felt more able to share their views. A new staff engagement group had been recently set up but staff seemed unclear what the remit of this group would be.
- The service collected patient feedback using voting tokens. The collection boxes were located on the main reception desk and in the relatives tea bar. Senior staff were looking into different ways of collecting feedback from patients and their families.
- Individual services, for example, bereavement support and the day hospice, collected patient feedback using questionnaires. We did not see any regular review or discussion of these reports at board or subcommittee level.
- The hospice had good presence in the local community with a number of local charity shops and a bereavement support group active in a local supermarket. An open evening, planned for March 2019 invited the public to an open event in the hospice grounds to learn more about services and fundraising.
- The service had annual thank you awards for volunteers. Senior leaders were hoping to set up something similar or complementary for staff to recognise their achievements.
- We saw evidence of change brought about by patient feedback. For example, different food portion sizes were introduced when some patients suggested this could better meet their changing needs. Privacy screens were added to the windows of rooms overlooked by the car park on the basis of family feedback, and free Wi-Fi was offered to improve the patient and visitor experience.

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.

- The service had developed effective working relationships with other hospices in the area. Managers had met with nearby hospices to share good practice. Across the region, hospices were investigating whether they could invest communally in training and shared learning for future leaders as this was an area that had the potential for efficiency savings.
- We also noted a significant improvement in the quality of senior leadership since our last inspection. Key leaders in new roles were making a big impact on the culture and professional working practices of the organisation and this was reflected in the fact that staff spoke very positively about the hospice and how much better it felt to work there.
- The care home project was an innovative way of working with other providers for the benefit of the wider system. Analysis showed that this was resulting in less unnecessary admissions to the hospice and the local hospital, and that care home staff were more confident in managing end of life patients.

Good

Hospice services for adults

- The hospice's work in the community with the hospital palliative care team meant that improved communication was keeping patients at home and they were not being admitted to the hospital unnecessarily if that was their wish. The service jointly audited care given by both teams, identifying areas for shared and separate learning, and where things had gone well.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all staff are trained to the appropriate level in safeguarding children. For staff working in public areas, we would expect this to be Level 2. (Regulation 13)
- The provider should ensure that all trustees receive an appropriate level of training in adult and child safeguarding. (Regulation 13)
- The provider should install a call bell or other alarm device in the quiet room, or take other precautions to ensure that in the event of an emergency, a patient or family member left in the room alone can raise the alarm. (Regulation 12)
- The provider should revisit the clinical risk register and the mechanisms and frequency of review to ensure that this is kept up to date and remains relevant. (Regulation 17)
- The provider should further improve their patient experience collection and reporting mechanisms, ensuring that the patient voice is heard and represented at all levels. (Regulation 17)
- The provider should further improve their monitoring and evaluation of qualitative outcomes for patients such as the effectiveness of spiritual and emotional support. (Regulation 17)
- The provider should consider the needs of marginalised or harder to hear segments of the local population and how the organisation might work to identify and reduce any barriers for people wishing to access hospice services. (Regulation 17)