Woking and Sam Beare Hospice and Wellbeing Centre

Quality Report

Goldsworth Park Centre
Woking
Surrey
GU21 3LG
Tel: 01483 881750
Website: www.wsbhospices.co.uk

Date of inspection visit: 3 December 2019
Date of publication: 12/03/2020

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

Summary of findings

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

We found the following areas of good practice:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Nigel Acheson

Deputy Chief Inspector of Hospitals. London and South East

Overall summary

Woking and Sam Beare Hospice and Wellbeing Centre is operated by Woking Hospice. The service has 20 beds, with 12 currently open. In addition, the service has a community nursing team, a hospice @ home service and wellbeing centre.

The service provides adult hospice care. We inspected this service using our comprehensive inspection methodology. We carried out the unannounced inspection on 3 December 2019.

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.

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.

Summary of findings

Contents

Good

Woking and Sam Beare Hospice and Wellbeing Centre

Services we looked at

Hospice services for adults

Summary of this inspection

Background to Woking and Sam Beare Hospice and Wellbeing Centre

Woking and Sam Beare Hospice and Wellbeing Centre is operated by Woking Hospice. The hospice was previously two hospices – Woking Hospice and Sam Beare Hospice who joined together to become one hospice in 2017. It is a hospice in Woking, Surrey. The hospice serves a population of more than 360,000 across six boroughs in North West Surrey.

At the time of the inspection, a new manager had recently been appointed and was in the process of registering with the CQC.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, an inspection manager, one other CQC inspector, and two specialist advisors with expertise in hospice care. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

How we carried out this inspection

The service provides adult hospice care. We inspected this service using our comprehensive inspection methodology. We carried out the unannounced inspection on 3 December 2019.

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.

Information about Woking and Sam Beare Hospice and Wellbeing Centre

The hospice has an inpatient unit, hospice at home service, a community nursing team and a wellbeing centre and is registered to provide the following regulated activities:

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

During the inspection, we visited the inpatient unit, the wellbeing centre and spent time with the community team visiting a patient in their home. We spoke with 43 staff including registered nurses, medical staff, health care assistants, allied health professionals, volunteers and senior managers. We spoke with five patients and one relative. During our inspection, we reviewed five sets of patient records. We reviewed information sent to us by the service prior to the inspection and data requested during the inspection.

There were no special reviews or investigations of the hospice ongoing by the CQC at any time during the 12 months before this inspection. This was the hospices first inspection since it became Woking and Sam Beare

Summary of this inspection

Hospice and Wellbeing Centre. Woking Hospice had been inspected in 2016 and was found to be good in all areas. Sam Beare Hospice had been inspected in 2016 and was found to be good in all areas.

Activity (December 2018 to November 2019)

In the reporting period December 2018 to November 2019 there were 310 inpatient stays and 1728 patients and 704 relatives attended the Wellbeing Centre. The average monthly caseload of the community team was 509 patients and the number of patients seen by the hospice @ home team was 175.

Track record on safety

- No serious incidents
- 167 Clinical incidents of which 133 resulted in no harm, 31 low harm, 03 moderate harm, zero severe harm and zero deaths
- No incidences of Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff) or E-Coli
- 3 formal complaints
- 829 compliments

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Interpreting services
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- Pharmacy support
- Infection prevent and control support

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated it as Good because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. When providing care in patients' homes staff took precautions and actions to protect themselves and patients.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Are services effective?

Good

We rated it as Good because:

Summary of this inspection

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- 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 monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff gave patients practical support to help them live well.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Are services caring?

Good

We rated it as Good because:

- People were truly respected and valued as individuals and empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service
- Feedback from people who used the service, those who were close to them and stakeholders was continually positive about the way staff treated people. People thought that staff went the extra mile and their care and support exceeded their expectations.
- People's emotional and social needs were seen as being as important as their physical needs.
- People were always treated with dignity by all those involved in their care, treatment and support. Consideration of people's privacy and dignity was consistently embedded in everything that staff did, including awareness of any specific needs as these were recorded and communicated.

Summary of this inspection

Are services responsive?

Good

We rated it as **Good** because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaints.

Are services well-led?

Good

We rated it as Good because:

- The leadership, governance and culture was used to drive and improve the delivery of high-quality person-centred care.
- Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired culture. Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond.
- The strategy and supporting objectives and plans are stretching, challenging and innovative, while remaining achievable. Strategies and plans are fully aligned with plans in the wider health economy, and there is a demonstrated commitment to system-wide collaboration and leadership.
- Staff are proud of the organisation as a place to work and speak highly of the culture. Staff at all levels are actively encouraged to speak up and raise concerns, and all policies and procedures positively support this process.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Summary of this inspection

- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- There were high levels of constructive engagement with staff and people who used services, including all equality groups. Rigorous and constructive challenge from people who use services, the public and stakeholders was welcomed and seen as a vital way of holding services to account.
- There was a systematic approach to improvement, which made consistent use of recognised improvement methodology. Improvement was seen as the way to deal with performance and for the organisation to learn. Improvement methods and skills were available and used across the organisation, and staff were empowered to lead and deliver change.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospice services for adults	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Hospice services for adults

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

Are hospice services for adults safe?

Good

We rated it as **good.**

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training topics included safeguarding children and adults, moving and handling, infection prevention and control, equality and diversity, fire safety, basic life support and health and safety. The training was a blend of e-learning and face-to-face sessions.

The service set a mandatory training completion target of 90% The overall compliance rate for mandatory training was over 90% for moving and handling, health and safety, fire safety, infection prevention and control, information governance, equity and diversity and food hygiene awareness. Basic life support training was 89% and medical gases 85%. Managers monitored mandatory training and alerted staff when they needed to update their training.

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.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding systems and processes ensured patient safety. The service had a safeguarding vulnerable adults policy which contained details on recognising and reporting abuse, this policy was due to be reviewed in 2021. This was accessible to staff on the service's intranet. Safeguarding flowcharts were visible in the offices of the inpatient unit and the wellbeing centre and had the details of who to contact in the event of identifying a safeguarding concern.

The service had a safeguarding training target of 90%. The service's training data showed that 100% of staff had been trained to Safeguarding Adults and children Level 1 and 76% of eligible staff had been trained to Safeguarding Adults and Children Level 2. Records showed that staff who had not completed the level 2 training where booked to do so and the service would be compliant with their 90% training target within eight weeks of the inspection.

The service's social worker was the operational lead for safeguarding and provided advice and support for staff making referrals and was trained to Safeguarding Adults and Children Level 4. The director of clinical services was the executive lead for safeguarding. The service had made no safeguarding referrals in the 12 months prior to inspection. During the inspection the inspection team were confident that staff would recognise a safeguarding concern and make the referral as needed. All staff we spoke with, including volunteers, could describe what constituted a safeguarding alert and describe the process for reporting this concern.

Cleanliness, infection control and hygiene

Good

Hospice services for adults

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean

The hospice had a service level agreement with the local NHS trust to provide infection control and prevention guidance. This included out of hours advice from a microbiologist. The team also provided local policy reviews and staff training which ensured all staff were up to date with current practice.

The service has an infection prevention and control (IPC) lead who attended monthly Clinical Quality Group & Health and Safety meetings. Records showed that the meetings discussed IPC incidents and infection rates.

All areas were clean and tidy and had suitable furnishings which were clean and well-maintained. Cleaning records we viewed were up-to-date and demonstrated that all areas were cleaned regularly. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff followed infection control principles that included the use of personal protective equipment (PPE). Personal protective equipment was available throughout the inpatient unit and wellbeing centre. Staff adhered to the service's arms bare below the elbows policy. We observed staff washing their hands before and after patient contact.

The service undertook hand hygiene audits for the inpatient unit and the wellbeing centre. Records for the 12 months prior to the inspection showed staff compliance with hand hygiene was 100%.

There were effective arrangements in place to prevent the spread of infection when caring for patients who had died. Systems ensured deceased patients left the hospice in a timely and dignified way and any risks of cross-infection were appropriately managed.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. Staff entry to the inpatient unit was by fob and an intercom system enabled relatives and patients to access the unit. Patients could reach call bells and staff responded quickly when called.

The service had enough suitable equipment to help them to safely care for patients. Staff told us that specialist equipment such as syringe drivers and hoists were readily available. The service had a room equipped with bariatric equipment to enable bariatric patients to be safely cared for on the inpatient unit. Bariatric equipment is equipment that is in place for patients with a high body mass index.

Staff disposed of clinical waste safely. The service had appropriate arrangements in place for the management of clinical waste and sharps. Arrangements for storing, classifying and labelling clinical waste kept patients and staff safe.

The service held an electronic register of electronic and medical devices that required servicing. The register listed the servicing expiry date. The service had a maintenance team who were onsite during working hours and provided an on-call service out of hours. Staff told us the maintenance team were responsive to calls and fixed equipment promptly.

Staff carried out daily safety checks of specialist equipment. The service had a defibrillator, which was located in the service's reception. 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. The defibrillator and pads were checked weekly and that staff we spoke with were aware of its location.

The service had suitable facilities to meet the needs of patients' families. The hospice had several quiet and reflection rooms, as well as two family pods, one on each side of the ward. These were equipped with kitchenettes, sofas, tables and chairs, SMART TVs, toys and entertainment for children. Families could stay overnight and had access to free internet.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service positively managed risks that people might experience at the end of their life, including risk of pressure ulcer and falls. Staff used nationally recognised tools to assess each person's risk of developing pressure ulcers.

Staff knew about and dealt with any specific risk issues. Staff completed an initial risk assessment within 12 hours of a patient being admitted and repeated this when a patient's circumstances changed. The service assessed the risks of pressure ulcers, manual handling, falls, venous thromboembolism (VTE), use of bedrails, nutrition, continence and mouthcare for all patients on admission.

Staff shared key information to keep patients safe when handing over their care to others. There were processes in place to escalate concerns with patient's deterioration and medical emergencies to senior nursing and medical staff. Senior nursing staff and medical staff were onsite seven days a week and could be accessed by telephone out of hours. Shift changes and handovers included all necessary key information to keep patients safe.

Comfort rounding was used to ensure patients were comfortable. Records indicated that staff assessed patients skin integrity, risk of falling, positioning for comfort, toilet requirements, mouthcare, food and drink offered, symptoms such as pain and nausea and that the environment was clutter free with the call bell to hand for the patient.

Patients who were at the end of their life were placed on the services personalised care for the last days of life plan. The plan included a medicines review, ensuring a Do Not Attempt Cardiopulmonary Resuscitation order (DNACPR) was in place, making note of any advance care plans and relatives wishes, nutrition and hydration assessments and care plans for pain management, agitation, respiratory symptoms, mouthcare, spiritual and psychological care. All five sets of patient records we reviewed had completed DNACPR forms.

Staffing

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

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The inpatient matron had the discretion to judge additional staffing levels based on the acuity of patients.

Inpatient referrals were assessed at the daily bed meeting. Patients numbers were managed to ensure sufficient staff were available; the service had the ability to decline patients if they felt that admitting them would be unsafe due to staffing levels.

Records showed the number of nurses and healthcare assistants matched the planned numbers. To ensure safe staffing levels at all times, the service used bank staff and staff worked flexibly across different service areas. The service ensured a senior nurse was always on duty on the inpatient unit and that staff had access to an on-call manager in and out of hours to escalate any staffing concerns that arose. The service did not use agency staff.

The service had reducing vacancy rates and turnover rates. The service had low reducing sickness rates. Managers limited their use of bank staff and requested staff familiar with the service. Managers made sure all bank staff had a full induction and understood the service. The service occasionally used agency staff who received a full orientation of the service.

The service had access to appropriate medical input. There was a minimum of one consultant and one junior doctor on duty during office hours and a consultant was on call outside these times. The hospice had onsite consultant cover from 9am to 5pm on weekdays. The consultants provided support to the inpatient unit and the community teams. There was a consultant on call from 5pm to 9am and throughout weekends to ensure twenty-four-hour, seven day a week cover. Doctors within the service told us that this was effective and gave the service access to consultants with a breadth of experience and allowed joined up working between the services.

Changes in patient acuity levels were reported at shift handovers. Handovers allowed enough time to assess each patients' escalating needs and staffing was flexed in response to changes.

All new staff received an orientation booklet, Continuing Professional Development folder and development pathway. Within the probation period, all mandatory training updates (as identified in Education policy training matrix) were completed via the Training Tracker e-learning programme and essential skills update via face to face training day. Individual training needs were identified at the three-month review (then ongoing annual appraisal) and offered appropriate support by the education team to access additional internal and external education/training opportunities.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely.

The service had a clinical record management policy which was due for review in November 2020. Patient notes were comprehensive. People's individual care records were written and managed in a way that kept people safe. Staff kept detailed records of patients' care and treatment. Patient records were stored securely in locked trolleys at the nurses stations.

We reviewed five patient care records. The records contained comprehensive and person-centered 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 weekly and particularly when a patient's circumstances changed.

Records showed the service audited ten community notes quarterly. We reviewed the last audit and it showed between a 90% and 100% compliance with good standards of record keeping.

Staff could access patient specific information from the care plan which included information on communication, psychological and mental health and end of life care. When patients transferred to a new team, there were no delays in staff accessing their records.

The information needed to deliver safe care and treatment was available to staff in a timely and accessible way. The day hospice and inpatient unit used an online system for recording of patient's records and the community service unit used paper-based records. However, there was a plan in place for the community service to have an electronic records system, commencing with community services, by December 2020.

Information needed for each patient's ongoing care was shared appropriately in a timely way. The service sought and obtained patient consent to share information with other services such as GP's. The service sent discharge letter to the patients GP by secure NHS e-mail.

The community staff team used a paper record system to record patient care. Paper records were taken to the patient's home in the staff members car. The risks around this practice concerned staff. We discussed this with the leadership team who had this as a documented risk on the risk register. There was a plan to move to an electronic record system which all staff with permission could access.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

We checked patient records and prescription chart for seven patients as well as looking at the medicines management group agenda and minutes, medicines standard operating procedures and policies and controlled drug records and drugs audit records.

The service had a controlled drugs accountable officer, who was undergoing training and a service lead for the safe and secure handling of medicines. The service had a service level agreement with the local NHS hospital for pharmacy support. The pharmacist worked part time on the inpatient unit and was available for support as part of the medicine's management team.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were stored safely and securely, in locked medicine cupboards within a treatment room. There was a system

in place to check that all medicines were within date and suitable for use. Night staff carried out nightly stock checks to ensure medicines had not expired and to place orders to replenish stock levels.

There were medicines available for use in an emergency and these were checked regularly. Medicines requiring cold storage were kept in a refrigerator within recommended temperature ranges and this was monitored daily.

Controlled Drugs (CDs), medicines that require additional controls because of their potential for abuse, were managed effectively. The controlled drugs were stored appropriately, and the service the service had recently installed a key management system with ID access for authorised staff. CDs were destroyed on the premises by a pharmacist and witnessed by a registered nurse. We saw that clear records of this were kept. Pharmacists carried out three monthly audits on controlled drugs. 21 members of staff were qualified to administer controlled drugs.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Nurse's CD competencies were checked annually, and doctors were provided with training on prescribing and the services policies by a trained pharmacist on induction. On admission doctors completed an inpatient medicines reconciliation report for patients which was then checked by a pharmacist for accuracy and signed.

For patients receiving medicines through a syringe pump, checks were carried out 4 hourly by nurses and this was clearly documented.

Staff had access to current references to ensure the correct and safe administration of medicines.

Patients were given clear information on the medicines they were receiving. We spoke with one patient who felt they were given clear and accurate information on medicines they were given and their expected effect. The patient felt able to ask questions and involved in decisions about their medicines.

At the time of our inspection, no patients were self-administering their medicines, systems were in place to support this should they wish to do so. Medicines administration records (MARs) were appropriately completed and there were no omissions.

Medicine related incidents were recorded and monitored, lessons were learnt and action plans were in place to ensure recurrence of errors was minimised. There was a system in place to ensure that medicines alerts or recalls were actioned appropriately.

Pharmacists reviewed the prescribed medicines for patients regularly and were involved in the training of staff on medicines optimisation. The pharmacy team were not directly involved in the hospice at home teams or day therapy service but there were representatives of both services at the medicines management meetings where any issues relating to medicines were discussed.

The service stored medical gases in line with manufacturers best practice guidelines. Used oxygen cylinders were stored in an external locked cage and cylinders that were in use were stored in a ventilated room that had signage stating that the room contained oxygen. The service had piped oxygen in all the rooms, which was maintained by an external company. However, this was checked weekly by the service's maintenance team.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff followed current national practice to check patients had the correct medicines. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Anticipatory medicines for distress, agitation, seizures and pain were prescribed and given in line with NICE guidelines for care of the dying adult in the last days of life and palliative care for adults.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole

team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The service had an incident policy which was due to be reviewed in 2022. Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy.

In the 12 months before inspection, the service reported no serious incidents. There were 167 clinical incidents of which 133 resulted in no harm, 31 low harm, 03 moderate harm, zero severe harm and zero deaths. Themes from incidents reported included drug administration errors, communication and concerns about care agency failings identified during home visits.

Staff we spoke to understood the duty of candour. Duty of candour is a legal duty to be open and honest with patients or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. They were open and transparent and gave patients and families a full explanation when things went wrong. Managers debriefed and supported staff after any serious incident. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff told us they received feedback from investigation of incidents and met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made because of feedback. For example, drug error themes are discussed in ward meetings.

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

Good

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.

The Education and Research Steering Group and Clinical Issues Group promoted and supported the use of latest changes in practice by disseminating new guidelines, alerts or changes in practice to clinical staff. Reviews of documentation, guidelines, audit outcomes and research were also discussed, and decisions made on how to incorporate changes into practice. For example, a drug chart review and a documentation review.

Competency Assessment Tools ensured that staff and volunteers had the appropriate qualifications and were encouraged to develop their skills. Learning needs were identified through monitoring and appraisal. Role appropriate training was provided.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

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'. 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 and developed with the consent of the patient.

The service monitored the review of National Institute of Clinical Excellence (NICE) guidance and Medicines and Healthcare products Regulatory Agency (MHRA) alerts as part of the services dashboards which were presented at the monthly board meetings. We viewed the dashboard and saw the guidance was assigned to an owner within the clinical team to review. There was a system in place to ensure that medicine alerts were actioned appropriately by the pharmacy team.

Patient's attending the hospice in both the wellbeing service and inpatient unit had the opportunity to develop an advance care plan. We saw in patient records that patients had the opportunity to create a specific guide to decision making in an emergency.

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 a nationally recognised screening tool to monitor patients at risk of malnutrition. Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it.

Patients received a nutrition and hydration assessment on admission. Staff used a nutrition screening tool to assess the food and hydration needs of patients. The nutritional assessments were completed in full in all the patient records we reviewed. Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Patient's nutrition and hydration was assessed and monitored as part of patients personalised care for the last days of life plan. This also included a mouthcare and oral hygiene plan. Discussions with patient's relatives about nutrition at the end of life were clearly documented in the plan.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients were offered a choice of meals from a menu each day and provided snacks and drinks throughout the day. Meal choices included adjustments made for patients' religious, cultural and other needs.

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' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The hospice managed the pain of people who were approaching the end of their life effectively. Staff assessed and monitored patients' pain in two-hourly comfort rounds during the day and hourly during the night. Patients told us they received pain relief soon after requesting it.

Patient's pain management was discussed in both the community and inpatient unit weekly multidisciplinary team meeting. We saw evidence in patients records of ongoing pain assessments undertaken.

Staff prescribed, administered and recorded pain relief accurately. We reviewed care records and saw patients had appropriate pain assessments and pain care plans. Staff recorded when as required medicines were prescribed and given for pain relief. Anticipatory medicines were prescribed appropriately in people identified as approaching the end of life.

Staff used an appropriate tool to help assess the level of pain in patients who were unable to communicate verbally.

Patient outcomes

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

The service monitored and benchmarked the quality of the services and the outcomes for patients receiving care and treatment. The service used the Integrated Palliative Care Outcome Score (IPOS). IPOS is a group of tools that measures a patient's physical symptoms, psychological, emotional and spiritual, and information and support needs. Each patient was given an IPOS score when they were discussed at the community and inpatient unit multidisciplinary team meeting.

The service participated in relevant national clinical audits such as Famcare Bereavement Audit which looked at the services evaluation of bereaved relatives' satisfaction with end of life care.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The programme included hand washing, falls management, controlled drugs and community stakeholder satisfaction. Managers shared and made sure staff understood information from the audits. Managers and staff used the results to improve patients' outcomes.

Competent staff

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

Managers gave all new staff a full induction tailored to their role before they started work. Induction on the inpatient unit was a three-week process where staff would spend the first two weeks completing classroom-based activities such as mandatory training and reviewing policies and procedures. All staff had a competency passport which recorded the skills and training.

The service had an education team who were responsible for delivering a programme of education around palliative and end of life care. The education programme was open to all staff and to external healthcare professionals. Teaching sessions and study days were prepared using best practice guidelines, research and published journal articles to support delivered content. Attendees were offered information to enhance their knowledge and skills as well as completing reflection on their practice. Palliative care update offered sessions highlighting key issues and topics relating to End of Life and Palliative Care. All staff were encouraged to attend a monthly journal club to review, discuss and share any relevant changes in practice standards.

Managers supported clinical staff to develop through yearly, constructive appraisals of their work. Staff told us that they completed annual appraisals with their mentors and that they found these meaningful.

The clinical educators supported the learning and development needs of staff. Patients had their needs assessed by staff with the right skills and knowledge. The service ensured that staff competencies were assessed regularly and had implemented a dedicated clinical teacher to train staff. Competency assessments for registered nurses included medicines, intravenous lines, blood transfusions, naso-gastric tubes and syringe drivers. Staff had a mentor responsible for signing off competencies.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

The service had volunteer coordinators who supported volunteers by providing them with training and by offering telephone support. Volunteers had a full induction programme which included face-to-face safeguarding training.

The human resources team monitored professional registration and revalidation for staff and sent reminders to staff when their registration and revalidation to professional bodies was due to be renewed.

Multidisciplinary working

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The wellbeing service held a multidisciplinary team meeting every morning to discuss patient's treatment goals and to discuss their progress against their care plans. This meeting was attended by clinical nurse specialists, healthcare assistants, physiotherapists, occupational therapists, activities coordinator and complementary therapist and the spiritual care lead. Care was then delivered to patients by the multidisciplinary team with patients able to access physiotherapy, occupational therapy, spiritual support, nursing support and complementary therapy in the day therapy setting.

The hospice's multi-disciplinary team represented all aspects of holistic care. The service ensured a patient's physical needs were met through medicine and physiotherapy support. Patient's psychological needs were supported through the services psychologists who offered support to both patients and their relatives. Patients social needs were met by the services social worker and spiritual needs were met by the services spiritual team.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff within the service told us they worked effectively with professionals from other services and could refer to mental health services if required.

Seven-day services

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

Good

Hospice services for adults

The inpatient unit provided care and treatment across seven days. The service ran seven days a week, 365 days a year. People could access most of the services seven days a week.

Daily consultant led ward rounds were conducted on the ward. Patients were reviewed by consultants depending on the care pathway. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. People who used services were empowered and supported to manage their own health, care and wellbeing and to maximise their independence.

The service focused on enhancing quality of life for all patients using the service. The day therapy service identified patients in need of extra support and provided emotional support in addition to physiotherapy and care planning.

The service ran healthy lifestyle workshops for patients and their families which included topics such as physical activity.

The day therapy service had a gym with specialised equipment to allow patients to alleviate common palliative symptoms such as breathlessness and to support patients to maintain their own health and wellbeing.

There were rooms in the hospice dedicated to complimentary therapies and art therapies.

Consent and Mental Capacity Act

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and they knew who to contact for advice.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. Staff within the hospice acknowledged they sought consent from patients before providing care and treatment. We saw written consent within the patients files we reviewed. Where a patient had been assessed as not having the capacity to consent to treatment, staff acted in their best interests and this was discussed and agreed at the multidisciplinary meeting.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. The service looked at each patient's mental capacity as part of the personalised care for the last days of life plan. We saw evidence that capacity was assessed prior to decisions about end of life care being made.

Are hospice services for adults caring?

Good

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.

The Education and Research Steering Group and Clinical Issues Group promoted and supported the use of latest changes in practice by disseminating new guidelines, alerts or changes in practice to clinical staff. Reviews of documentation, guidelines, audit outcomes and research were also discussed, and decisions made on how to incorporate changes into practice. For example, a drug chart review and a documentation review.

Competency Assessment Tools ensured that staff and volunteers had the appropriate qualifications and were encouraged to develop their skills. Learning needs were identified through monitoring and appraisal. Role appropriate training was provided.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

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'. 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 and developed with the consent of the patient.

The service monitored the review of National Institute of Clinical Excellence (NICE) guidance and Medicines and Healthcare products Regulatory Agency (MHRA) alerts. There was a system in place to ensure that medicine alerts were actioned appropriately by the pharmacy team.

Patient's attending the hospice in both the wellbeing service and inpatient unit had the opportunity to develop an advance care plan. We saw in patient records that patients had the opportunity to create a specific guide to decision making in an emergency.

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 a nationally recognised screening tool to monitor patients at risk of malnutrition. Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it.

Patients received a nutrition and hydration assessment on admission. Staff used a nutrition screening tool to assess the food and hydration needs of patients. The nutritional assessments were completed in full in all the patient records we reviewed. Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Patient's nutrition and hydration was assessed and monitored as part of patients personalised care for the last days of life plan. This also included a mouthcare and oral hygiene plan. Discussions with patient's relatives about nutrition at the end of life were clearly documented in the plan.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients were offered a choice of meals from a menu each day and provided snacks and drinks throughout the day. Meal choices included adjustments made for patients' religious, cultural and other needs.

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' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The hospice managed the pain of people who were approaching the end of their life effectively. Staff assessed and monitored patients' pain in two-hourly comfort rounds during the day and hourly during the night. Patients told us they received pain relief soon after requesting it.

Patient's pain management was discussed in both the community and inpatient unit weekly multidisciplinary team meeting. We saw evidence in patients records of ongoing pain assessments undertaken.

Staff prescribed, administered and recorded pain relief accurately. We reviewed care records and saw patients had appropriate pain assessments and pain care plans. Staff recorded when as required medicines were prescribed and given for pain relief. Anticipatory medicines were prescribed appropriately in people identified as approaching the end of life.

Staff used an appropriate tool to help assess the level of pain in patients who were unable to communicate verbally.

Patient outcomes

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

The service monitored and benchmarked the quality of the services and the outcomes for patients receiving care and treatment. The service used the Integrated Palliative Care Outcome Score (IPOS). IPOS is a group of tools that measures a patient's physical symptoms, psychological, emotional and spiritual, and information and support needs. Each patient was given an IPOS score when they were discussed at the community and inpatient unit multidisciplinary team meeting.

The service participated in relevant national clinical audits such as Famcare Bereavement Audit which looked at the services evaluation of bereaved relatives' satisfaction with end of life care.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The programme included hand washing, falls management, controlled drugs and community stakeholder satisfaction. Managers shared and made sure staff understood information from the audits. Managers and staff used the results to improve patients' outcomes.

Competent staff

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

Managers gave all new staff a full induction tailored to their role before they started work. Induction on the inpatient unit was a three-week process where staff would spend the first two weeks completing classroom-based activities such as mandatory training and reviewing policies and procedures. All staff had a competency passport which recorded the skills and training.

The service had an education team who were responsible for delivering a programme of education around palliative and end of life care. The education programme was open to all staff and to external healthcare professionals. Teaching sessions and study days were prepared using best practice guidelines, research and published journal articles to support delivered content. Attendees were offered information to enhance their knowledge and skills as well as completing reflection on their practice. Palliative care update offered sessions highlighting key issues and topics relating to End of Life and Palliative Care. All staff were encouraged to attend a monthly journal club to review, discuss and share any relevant changes in practice standards.

Managers supported clinical staff to develop through yearly, constructive appraisals of their work. Staff told us that they completed annual appraisals with their mentors and that they found these meaningful.

The clinical educators supported the learning and development needs of staff. Patients had their needs assessed by staff with the right skills and knowledge. The service ensured that staff competencies were assessed regularly and had implemented a dedicated clinical teacher to train staff. Competency assessments for registered nurses included medicines, intravenous lines, blood transfusions, naso-gastric tubes and syringe drivers. Staff had a mentor responsible for signing off competencies.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

The service had volunteer coordinators who supported volunteers by providing them with training and by offering telephone support. Volunteers had a full induction programme which included face-to-face safeguarding training.

The human resources team monitored professional registration and revalidation for staff and sent reminders to staff when their registration and revalidation to professional bodies was due to be renewed.

Multidisciplinary working

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The wellbeing service held a multidisciplinary team meeting every morning to discuss patient's treatment goals and to discuss their progress against their care plans. This meeting was attended by clinical nurse specialists, healthcare assistants, physiotherapists, occupational therapists, activities coordinator and complementary therapist and the spiritual care lead. Care was then delivered to patients by the multidisciplinary team with patients able to access physiotherapy, occupational therapy, spiritual support, nursing support and complementary therapy in the day therapy setting.

The hospice's multi-disciplinary team represented all aspects of holistic care. The service ensured a patient's physical needs were met through medicine and physiotherapy support. Patient's psychological needs were supported through the services psychologists who offered support to both patients and their relatives. Patients social needs were met by the services social worker and spiritual needs were met by the services spiritual team.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff within the service told us they worked effectively with professionals from other services and could refer to mental health services if required.

Seven-day services

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

The inpatient unit provided care and treatment across seven days. The service ran seven days a week, 365 days a year. People could access most of the services seven days a week.

Daily consultant led ward rounds were conducted on the ward. Patients were reviewed by consultants depending on the care pathway. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. People who used services were empowered and supported to manage their own health, care and wellbeing and to maximise their independence.

The service focused on enhancing quality of life for all patients using the service. The day therapy service identified patients in need of extra support and provided emotional support in addition to physiotherapy and care planning.

The service ran healthy lifestyle workshops for patients and their families which included topics such as physical activity.

The day therapy service had a gym with specialised equipment to allow patients to alleviate common palliative symptoms such as breathlessness and to support patients to maintain their own health and wellbeing.

There were rooms in the hospice dedicated to complimentary therapies and art therapies.

Consent and Mental Capacity Act

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and they knew who to contact for advice.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. Staff within the hospice acknowledged they sought consent from patients before providing care and treatment. We saw written consent within the patients files we reviewed. Where a patient had been assessed as not having the capacity to consent to treatment, staff acted in their best interests and this was discussed and agreed at the multidisciplinary meeting.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty

Safeguards. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. The service looked at each patient's mental capacity as part of the personalised care for the last days of life plan. We saw evidence that capacity was assessed prior to decisions about end of life care being made.

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

Good

We rated it as **good.**

Compassionate care

People were truly respected and valued as individuals and were empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The hospice had a Promoting Privacy, Dignity and Respect Policy which was due for review in 2022.

Staff rostering endeavoured to ensure that staff had enough time to spend with patients and their families and to respect their cultural, social and religious needs. They supported patients who were frightened or confused and ensured that their needs were actively explored.

Patients were encouraged to maintain their social networks. Emotional support was provided by the bereavement counselling, complementary therapy and spiritual services. Staff were able to "signpost" to other services and professional associations for additional support and advocacy which included befriending.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders. Patients said staff treated them well and with kindness. We observed staff being continually kind and compassionate as they put patients and their relatives at ease.

Feedback from people who used the service, those who are close to them and stakeholders was continually positive about the way staff treat people. People thought that staff went the extra mile and their care and support exceeds their expectations.

We were provided with results from this feedback which was all highly positive.

Examples of patient feedback included:

"I feel you were very professional and couldn't have been kinder or more supportive to us both"

"I felt very safe in your hands and your patience with xx when he struggled to communicate was outstanding. All the things you said you would do happened instantly"

"Every single member of staff from the wonderful doctors and nurses, right down to the lovely ladies who delivered the food and the afternoon tea and cakes were so caring and couldn't do enough to make sure my husband was comfortable"

Patient's individual preferences and needs were always reflected in how care was delivered. For example, we saw a patient living with dementia had a list of things she like to eat and how she wished her hair to be styled.

The service held birthday parties, weddings and other special occasions in the garden or in the day service room, so that patients could celebrate these special occasions with their loved ones.

Nursing staff were passionate about creating positive memories for patients and their families when staying at the inpatient unit. Staff enabled families to eat together, if the patient was well enough they would eat at a table in the communal area away from the patient room.

Staff followed policy to keep patient care and treatment confidential. Staff consideration of people's privacy and dignity was consistently embedded in everything that staff did. Staff ensured they protected patient dignity when providing personal care by closing doors and curtains to bedrooms.

The dignity of deceased patients was maintained through the services processes for performing last offices and the deceased person remained in their bedroom with the use of cold blankets prior to collection by a funeral home. Last offices is the process to prepare the deceased for a funeral home and involves washing the patient.

Emotional support

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

We saw staff were positive and attentive to the needs of patients at the hospice.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff providing kind, thoughtful, supportive and empathetic care. Relatives also commented on how supportive the staff were. They provided them with assurance and reassurance which enabled patients to relax and settle well into the hospice and accept the care and support provided.

People were always treated with dignity by all those involved in their care, treatment and support. Consideration of people's privacy and dignity was consistently embedded in everything that staff did, including awareness of any specific needs as these were recorded and communicated.

Relatives could attend one on one bereavement sessions with a psychologist or bereavement support groups. One relative that we spoke with told us the nursing staff provided emotional support to them daily.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. 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.

Staff recognised and respected the totality of people's needs. They always took people's personal, cultural, social and religious needs into account, and found innovative ways to meet them. The aim of the service was to relieve as many worries for a patient as possible, so they could concentrate on caring for the whole person and their relatives.

Patient's emotional and social needs were seen as being as important as their physical needs.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff recognised the need for patients and those close to have access to, and links with, their advocacy and support networks in the community and the service provided support to them to do this.

The service ran three support groups for bereaved children. Footsteps was for children aged eight to twelve years old. The group provided practical and creative activities to support bereaved children and the emotional needs. The Tommy D Project was for children under 18 and The HUB (help understanding bereavement) Programme offered a six-week course for children who had experienced bereavement.

The complimentary therapy team offered a range of therapies to support patients and their relatives including massage and aromatherapy.

The spiritual care team ran events to support and remember loved ones such as the annual Christmas tree lighting event and remembrance and thanksgiving events for relatives who lost a loved one in the last year.

The service had a pets as therapy (PAT) dog service that attended the inpatient unit and wellbeing centre to allow patients and their relatives to pet dogs to improve wellbeing. The service also encouraged patients to bring in their own pets.

The wellbeing centre included the option to take part in wellbeing crafts including conducting life story work with patients which allowed them to create memory boxes, photobooks, video diaries and audio recordings of their lives. The service also provided music therapy sessions. On the day of the inspection a community choir and bell ringing club visited the wellbeing centre. We observed patients enthusiastically participating and enjoying the visits.

Understanding and involvement of patients and those close to them

Good

Hospice services for adults

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

People who used services and those close to them are active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person.

The service had a visible patient-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity and independence where possible.

Staff made sure patients and those close to them understood their care and treatment. Staff made sure that people who used services and those close to them were able to find further information, including community and advocacy services. They could ask questions about their care and treatment. Staff were fully committed to working in partnership with people and making this a reality for each patient. Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff routinely involved people who used services and those close to them (including carers and dependants) in planning and making shared decisions about their care and treatment.

The organisation conducted ongoing patient and relative satisfaction survey in the inpatient unit, the coordinated, safe and integrated (CoSI) team and Wellness and Counselling. The Wellness and Therapy service and community team conducted patient surveys twice a year. This included the relatives of patients who had died. Records showed consistently high satisfaction scores across the organisation. Almost 100% of those who responded agreed or strongly agreed with positive statements about their experience when accessing the service.

People's carers, advocates and representatives including family members and friends, were identified, welcomed, and treated as important partners in the delivery of their care. Patients told us they valued the relationships they built with the staff and they felt staff often went 'the extra mile' for them when providing care and support.

The service worked closely with the Muslim Community and with local businesses, schools and church groups.

We saw evidence in patient care records that staff involved patients and those close to them in the decisions about the patients' care and treatment and in developing their care plans. Patients and their relatives told us the staff answered questions about care and treatment openly and the information provided to them was clear. We observed the community nursing staff involving and engaging patients and their relatives in discussions about care planning.

Staff supported patients to make advanced decisions about their care. Patients were provided with support and information about their options for care, and conversations were had with patients about their preferred place of death. We saw staff talking to patients and their families about death and the dying process. They were very compassionate and caring towards patients or family members who became upset. They enabled the family of the patient to ask as many questions as they wanted to.

Are hospice services for adults well-led?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the changing needs of the local population. The service provided end of life care for individuals requiring care and support outside of their NHS care.

The community and day care services offered a range of appointments to meet the needs of the patients who used the service. The managers told us there was mixed demand for appointment times and they would offer appointments to suit the needs of patients. Appointments were available early in the morning or later in the evening to accommodate patient's schedules.

The service had engaged actively with different faith groups in the local community and had a group that met to look at how to reach different groups within the community.

Facilities and premises were appropriate for the services being delivered. The environment was appropriate and patient centred with comfortable seating and access to facilities such as toilets and a play area for young children. The design of the inpatient unit had been created with the needs of patients and their relatives at the forefront of planning. Each room had a dementia friendly clock.

All of the rooms were en-suite and spacious and allowed for several family members to attend. All rooms had access to outdoor space with view into the hospice's award-winning gardens. Families were allowed to stay overnight with their relatives.

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

The service had a multi-faith quiet space which was called the retreat, that was a space which could be used by patients and their relatives to reflect, pray, meditate or just to sit in a quiet space.

There was local access to the service by car or public transport with areas dedicated to car parking. The reception area was clean and tidy with access to leaflets about palliative care and fund-raising initiatives.

The service had projects in place to improve end of life care in the community and to access patients that would not usually access their services by providing teaching and education on end of life care to care homes and to other healthcare professionals.

Meeting people's individual needs

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

The service discussed equality related issues within the equality steering group. The hospice recently facilitated a day of knowledge sharing and discussion with guest speakers and experts in working with people from under-represented groups with a focus on those living with dementia, learning disabilities and their carers. A poster competition was held to enable clinical teams to showcase their work and innovations in practice. The conference was well attended, very positively evaluated and enabled the service to enhance relationships and collaborative working with local groups and organisations. The success of the project helped to initiate development of an equalities strategy to replicate and further good practice and access to end of life care for all underrepresented groups.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff had received training on working with patients with specific needs such as those living with dementia.

Managers made sure staff, and patients, relatives and carers could get help from interpreters or signers when needed. A variety of leaflets were available on the inpatient unit including information about the last days of life. The leaflets had different languages on the back explaining that the leaflets were available in different languages and email and telephone details to have them printed and sent. The leaflets were also available in different formats such as large print.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had arrangements in place to access translation services for patients. Staff we spoke with could tell us how they would access these services and provided examples of occasions that they had done so.

We reviewed five care plans and saw that services were coordinated with other agencies to provide care to patients with more complex needs. Staff could give examples of when they had referred patients to community services. 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.

All care records contained a 'getting to know me' document that detailed the patient's needs and preferences and took account of any additional needs such as dementia and behavioural needs.

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.

The service focused on individual needs and goals in planning care for patents in the community. Patients goals would be identified, and a plan put in place to achieve the goals.

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

The service had an award-winning garden which was used by patients when they were well enough.

The service had a business continuity plan that covered various issues including power failure and flood.

The service had two bariatric rooms which were fully equipped for bariatric patients.

Access and flow

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

Staff supported patients when they were referred or transferred between services. The service had processes in place to manage admission to the service. The service had an admissions and referrals team who monitored and forwarded referrals and admissions to the appropriate service. Referrals came through from the local hospitals and GPs.

Referrals into the inpatient unit were reviewed at the daily admission meetings Patients had fast track admissions anytime of day, either direct from the community or transfer from hospital.

Staff discussed service provision at weekly multidisciplinary meetings. Using the links the service had developed with community services, the end of life care co-ordination service and occupational therapy service worked to ensure that appropriate patients were discharged to their preferred place of care. This meant freeing up capacity to admit those on the waiting list. Co-ordinate my care records supported patients to be enabled to die in their preferred place.

The outpatient's services capacity was based on the maximum number of patients able to attend a group or service at one time

Learning from complaints and concerns

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

The service had a complaints, concerns and compliments management policy which was due to be reviewed in 2021. Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes.

The practice development team provided complaints management awareness and management training to staff. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice.

People we spoke with told us they knew how to make a complaint or raise concerns and felt comfortable doing so. Staff understood the system and had access to policy and procedures to guide them in managing complaints.

Good

Hospice services for adults

People who used the system to make a complaint or raise concerns were treated compassionately and given the help and support. Staff received specific communication training to help them respond sympathetically to people who were distressed, or who were dissatisfied.

During the 12 months prior to inspection the service received three formal complaints. Three complaints were upheld following the investigation. The service had a target of responding to complaints within 20 days and we saw evidence that the service had met this target in all but one complaint.

Staff were expected to report and escalate any concerns so that they could be practically addressed if necessary where the concern was not resolved immediately.

We saw posters and leaflets at the service that told people how to and who to complain to. These were in the reception area and the inpatient areas where people could see them.

The service had a clear process in place for capturing and learning from negative feedback which was not submitted as a complaint. The service captured this feedback as "concerns" and monitored and discussed both concerns and formal complaints clinical risk management group meetings. We saw that solutions to concerns were discussed and agreed actions were assigned to members of staff.

In the 12 months before inspection the service received 829 compliments. All compliments were logged and feedback to the relevant staff.

Are hospices for adults services well-led?

Well-led means that the leadership, management and governance of the organisation make sure it provides high-quality care based on your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

We rated it as **good.**

Leadership

The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care

There was compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care.

The senior leadership team had been brought into post six months before the inspection and had made significant improvements to the leadership and culture of the service since commencing their role. For example, staff at all levels had undergone a pay and job role review that ensured equity of workload and reward across the service. Governance and reporting structures had been reviewed and reorganised. Staff members had changed their minds about leaving the service and other staff who had left the organisation were happy to return.

The senior management team reported to the chief executive officer. Leaders included a director of fundraising, medical director, human resources director, volunteer's coordinator, finance director, director of clinical services, marketing and communications director, business manager, head of retail and health and safety advisor.

The management were committed and passionate about patient care and a high-quality service. They understood the challenges the service faced, in particular, the funding challenges experienced by hospices and the impact this could have on the service.

Staff told us they felt supported by the management and that they were friendly and approachable. Staff felt confident in approaching them regarding issues to do with their professional or personal life.

Leaders within the service went out of their way to ensure that they were visible and approachable. Staff told us that leaders from all levels within the organisation were approachable and supportive and that members of the senior leadership team could be seen regularly on the inpatient unit and would offer support if the unit was busy.

Concerns raised by staff were always acted upon by managers, feedback was given, and learning was always disseminated staff.

All staff felt valued and told us that they enjoyed working at the hospice. Throughout the inspection, we saw that staff assisted each other with tasks, and responded quickly to service needs.

Good

Hospice services for adults

The clinical service lead was very committed to the staff, the patients and the service. This was reflected in the way the team was led and kept patients at the heart of service delivery. They felt strongly about trusting and empowering the staff team and advocated an autonomous approach to the work undertaken.

Staff felt connected to other teams within the service and the organisation. The community nursing team told us they worked well with teams from the inpatient unit and the wellbeing centre.

Vision and strategy

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

The strategy and supporting objectives and plans were stretching, challenging and innovative, while remaining achievable. Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership.

The service's vision was to 'deliver high quality specialist care and support to anyone with a life-limiting illness, at the time they need it and in the place of their choice'. All the staff we spoke with were fully aware of and proud of the vision of the service.

The service had a business plan for 2020/2021 which was aligned to the five-year strategic plan 2018/2023, which encompassed all its services. The service had sought the views of patients and staff when creating the plan and endeavoured to align the plan with Hospice UK guidance, national strategy and the local sustainability and transformation partnership for end of life care.

The service displayed in the way they worked a strong clear emphasis on continual improvement and development and sustainability of the service. Records showed the executive committee met quarterly. Standard agenda items for discussion included the marketing and communication campaign, finance update, review of cost savings plan, human resource update, inspection preparation and the fundraising action plan.

Records showed the hospice board met quarterly. The meeting had a standing agenda and discussed the hospices vision and strategy, monitored action plans and relationships with the key stakeholders in the wider health economy.

The service demonstrated they recognise the ongoing importance of ensuring staff had total buy in to the vision and values of the service, they ensured they were understood, implemented and communicated to people in meaningful and creative ways.

The service published an annual report which contained end of year financial statements, chairman and chief executive reports and the trustees report.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired culture. Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond.

The service had a whistleblowing policy which was available to all staff and staff we spoke to knew how to raise concerns.

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.

All staff we spoke with were positive about working for the hospice. They described feeling valued and supported in their role. Staff who worked remotely said they felt connected to the team and to the organisation. The service valued the contribution of its volunteers.

There was a universal recognition of the importance of ensuring patients received a good end of life care experience across all staff groups and services. Staff were fully engaged with the hospice and very proud of the care and treatment they provided for patients.

The culture of the service encouraged openness and honesty. We reviewed incident and investigation reports and saw the service did not have any need to use duty of candour. 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.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Governance arrangements were proactively reviewed and reflected best practice. A systematic approach was taken when working with other organisations to improve care outcomes. The service had a clear governance process to continually improve the quality of service provided. Staff understood their roles and responsibilities in relation to governance. Governance arrangements were clear and appropriate to the size of the service.

The service had a strong governance structure that supported the feed of information from frontline staff to senior managers and trustees. The hospice held team meetings. These meetings in turn fed into the service's board meetings. The board meetings were attended by senior members of staff in the organisation including the chief executive officer, director of clinical services, medical director, human resources director, director of finance, director of fundraising, director of marketing and communications in addition to the trustees. The service also held clinical governance committee meetings which were chaired by the medical director, these meetings were held four times per year.

There were clear lines of accountability in the service. The service had nominated leads in areas such as safeguarding and infection prevention and control. These leads reported on these areas during board meetings.

Managing risks, issues and performance

There was a demonstrated commitment to best practice performance and risk management systems and processes.

The service had a combined risk register of clinical and corporate risks. These had recently been combined to improve oversight of the risk across the whole organisation. Senior managers described the main risks to the service which we noted were on the risk register. Mitigating actions and responsible person in charge of the risk had been clearly noted, along with review dates.

Records showed that risks across the organisation where discussed at the quarterly clinical and corporate overview and scrutiny committee which was chaired by the director of nursing. These were superseded by monthly clinical quality group meetings chaired by the director of clinical services. Risks included manual paper records, staffing levels and future funding for the hospice.

The service had a business continuity plan that covered various issues including loss of access to electronic patient records, loss of electricity, loss of water supply, and fire.

The staff understood what its key risks were and there was good oversight of them. The service reviewed compliments, complaints and any concerns that had arisen. Concerns were discussed by the clinical lead and actions identified and assigned to senior staff members.

There were clear lines of accountability in the service. The service had nominated leads in areas such as safeguarding and infection prevention and control. These leads reported on these areas during the monthly clinical quality group meetings. All information was fed to the governance committee and board on a quarterly basis.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance,

make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service invested in innovative and best practice information systems and processes. The information used in reporting, performance management and delivering quality care was consistently found to be accurate, valid, reliable, timely and relevant.

Information governance training formed part of the mandatory training programme for the service, and staff we spoke with understood their responsibilities regarding information management.

All IT systems were protected by security measures, all staff including bank staff had individual log on details and access to patient information was restricted depending on staff role. Computer screens were locked when staff were not sitting at their desks to prevent information breaches.

The service was registered with the information commissioner's office and the medical director was the nominated caldicott guardian for the service.

Engagement

There were consistently high levels of constructive engagement with staff and people who used services, including all equality groups. Rigorous and constructive challenge from people who use services, the public and stakeholders was welcomed and seen as a vital way of holding services to account.

Leaders had an inspiring shared purpose, and strived to deliver and motivate staff to succeed. There are high levels of satisfaction across all staff, including those with particular protected characteristics under the Equality Act.

The service engaged well with patients, staff, volunteers and the public and local organisations to plan and manage appropriate services and collaborated with partner agencies effectively.

Employees completed an annual staff survey. The results of the survey were largely positive with staff answering positively to questions asking if the service's vision, mission and valued mattered to them, that the role the worked in was as they expected it to be and their colleagues were committed to doing quality work.

The service ran a patient survey for service users to give their feedback about their experience, we saw the results from patient feedback was overwhelmingly positive.

We saw that the service responded to any comments made to improve the quality of the experience.

There was regular communication with staff via the staff newsletter and the intranet pages.

The service held various staff awards to recognise staff contribution which included long service awards for long serving staff members. Staff were proud to show us awards and recognition they had received from the leaders for their hard work.

The service provided a newly bereaved support group and three support groups for bereaved children.

Learning, continuous improvement and innovation

There was a fully embedded and systematic approach to improvement, which made consistent use of a recognised improvement methodology. Improvement was seen as the way to deal with performance and for the organisation to learn. Improvement methods and skills were available and used across the organisation, and staff were empowered to lead and deliver change.

The service was committed to improving services by learning from when things went well or not so well and promoted training and innovation.

The service was committed to providing regular training opportunities to staff. We saw information about education sessions including sage and thyme, introduction to end of life care for staff and volunteers, last days of life, symptoms management and drugs in end of life care. The service had also introduced Schwartz rounds, which was a programme designed to support staff and volunteers with discussing emotional and social issues arising from patient care.

Good

Hospice services for adults

The service was proactive in seeking feedback from staff, volunteers and patients and could provide multiple examples of where service improvements had been implemented as the result of this engagement.

Staff had published peer reviewed articles in the national nursing press and presented several posters at national palliative conferences.

Outstanding practice and areas for improvement

Outstanding practice

- Feedback from people who used the service, those who are close to them and stakeholders was continually positive about the way staff treat people.
- The service worked closely with the Muslim Community and with local businesses, schools and church groups.
- Patient's emotional and social needs were viewed as being as important as their physical needs.
- The service ran three support groups for bereaved children. Footsteps was for children aged eight to twelve years old. The group provided practical and creative activities to support bereaved children and the emotional needs. The Tommy D Project was for children under 18 and The HUB (help understanding bereavement) Programme offered a six-week course for children who had experienced bereavement.
- The staff were overwhelmingly positive about the change in culture and improvements made since the new leadership team had come into post.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure all staff attend mandatory training to meet the services minimum attendance targets.