

Mary Ann Evans Hospice

Mary Ann Evans Hospice

Inspection report

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

Ratings

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

Summary of findings


Overall summary

Our rating of this service stayed the same. We rated it as good because:

- 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 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.
- 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.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Good 	Our rating of this service stayed the same. We rated it as good. See the summary above for details.

Summary of findings

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Summary of this inspection

Background to Mary Ann Evans Hospice

Mary Ann Evans Hospice provides a day care service for people with life limiting conditions, a hospice at home service for people moving towards the end of their lives, a 24-hour rapid response service to support patients at home with symptom management. They provided a service to alleviate the symptoms for people with lymphoedema, a condition which can occur after cancer surgery or radiation therapy. In addition, they provide a family support and bereavement service for patients and those close to them. The hospice provides care to adult patients and support to their families.

The director of clinical services is the CQC registered manager. The service is registered with the CQC to provide the following Regulated Activity:

Treatment of disease, disorder or injury.

The service was last inspected in August 2014 where they were rated good.

How we carried out this inspection

We visited the hospice and spoke with staff delivering services. We held interviews with service leads. We spoke with 16 staff including the chief executive, director of clinical services, associate director of clinical services, associate director of people development and education, registered nurses, care support workers, family support staff and administrative staff. We also spoke with 4 patients who received care from the service. We carried out a home visit where we spoke with 1 patient and their relative and observed the care provided. We reviewed data about the service and reviewed 5 patient care and medicines records. We reviewed data and governance documents including 3 staff files.

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

Areas for improvement

Action the service **SHOULD** take to improve:

- The service should ensure that links within policy documents are up to date.

Our findings

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

Hospice services for adults

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

Is the service safe?

Good 

Our rating of safe stayed the same. 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. Overall mandatory training compliance for the clinical team was at 90%.

The mandatory training was comprehensive and met the needs of patients and staff. Modules included infection control, health and safety, information governance, safeguarding, fire safety and basic life support.

Clinical staff completed some training on recognising and responding to patients with mental health needs, a learning disability, autism and dementia. Staff had historically completed dementia friends training, however, since then there had been a turnover of staff so not all staff had completed this training. Managers told us they were investigating the possibility of updating training in this area. The associate director of people development and education was attending a national hospice specific workshop in March 2023 to learn more about hospice training requirements. Following this a training plan for the year ahead would be developed. The hospice had committed to training staff on learning disabilities and autism.

Managers monitored mandatory training and alerted staff when they needed to update their training. The education coordinator sent monthly communication to individual staff and their line managers alerting them to training that was overdue or was required to be completed.

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.

Hospice services for adults

Staff received training specific for their role on how to recognise and report abuse. Clinical staff had completed level 1 and level 2 safeguarding training for both children and vulnerable adults. Training compliance on safeguarding modules was between 87 and 94%. Service leads worked closely with local safeguarding leads to identify the level of training required for each grade of staff. Some senior staff had completed safeguarding training to level 3 and the hospice had recently decided to train all band 6 and above nursing staff to level 3. This was in progress at the time of the inspection.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They had received training in and had a good understanding of protected characteristics. The hospice safeguarding and equality and diversity policies detailed clear responsibilities in relation to equal access to services and care for all people with protected characteristics, including disabilities, age, race, sexual orientation and gender.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They worked closely with other agencies including community and hospital services, as well as local safeguarding teams to ensure that individual patients and those close to them were protected.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff knew how to escalate safeguarding concerns and had access to local authority safeguarding teams.

Cleanliness, infection control and hygiene

Staff used infection control measures when caring for patients.

Patient areas were clean and had suitable furnishings which were visibly clean and well-maintained.

The service generally performed well for cleanliness and infection control. We reviewed an infection prevention and control audit that was completed in May 2022 and saw that compliance was high. They were 100% compliant for both management systems and personnel and screening, protection and training and the provision of information. They were 87.5% compliant for policies and procedures and 85% compliant for control of environment. An action plan to monitor improvement was in place and had been completed. Specific action included updates to policies and procedures, maintenance updates and bin replacement.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE) and were bare below the elbow when working clinically. Service leads had risk assessed the use of PPE and a decision had been made for staff and visitors to continue to wear face masks when caring for patients or on site at the hospice, this was due to patients being more vulnerable to infections. Staff had access to the full range of PPE and had received training in donning and doffing. Staff told us that PPE was readily available. Risk assessments were carried out for all patients accessing the services and the level of PPE was determined based on the risks. For example, where personal care was provided or where there was a risk of infection transmission.

Staff cleaned equipment after patient contact. Additional cleaning was carried out on essential equipment. For example, hoists were cleaned daily, as well as between each patient use.

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.

Hospice services for adults

The design of the environment followed national guidance. The maintenance of the premises included safety checks and processes in relation to fire safety, water safety, environmental risks and ongoing upkeep.

Staff carried out daily safety checks of specialist equipment. This included patient hoists, wheelchairs and other patient related equipment for use in the wellbeing and lymphoedema (a condition which can occur after cancer surgery or radiation therapy) services.

The service ensured facilities were suitable to meet the needs of patients and their families. Staff carried out environmental risk assessments as part of their assessment processes when caring for patients in their homes. This included risks to patients and staff. Mitigating actions were taken as appropriate, including liaising with local community teams to ensure that appropriate equipment was available.

The service had enough suitable equipment to help them to safely care for patients. The service had a store of syringe drivers that were used to administer medicines on a continuous basis to people in the community who required medicines in this way to help control their symptoms. We saw staff checked equipment was working properly during home visits. The hospice maintained an equipment register and ensured appropriate maintenance, calibration and electrical safety checks were carried out.

Staff disposed of clinical waste safely. They had a contract with the local NHS trust to dispose of clinical waste. Waste was seen to be stored appropriately in relevant colour coded waste disposal bags and bins.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff identified patients based on their phase of illness through regular monitoring of outcome scales and recognised patients who were in the last days of life. The phase of illness scale identifies patients who are stable, unstable, deteriorating or dying. The assessment scale was used periodically when caring for patients to help identify deterioration. Staff discussed changes with the multi-disciplinary team, including hospital, community and GP colleagues to ensure patients received appropriate care and support.

Staff completed risk assessments for each patient when first using the service and reviewed this regularly, including after any incident. Assessment tools were used to identify risks relating to falls, pressure ulcers, malnutrition, mobility and other potential risks relating to care.

Staff knew about and dealt with any specific risk issues. Staff had a good understanding of the risks associated with end of life care. Nursing staff had completed training in areas such as health assessment and the management of breathlessness. All clinical staff had completed basic life support training and some care support workers had completed additional training in bedside emergencies. This included assessing the risk of airway, breathing and circulation concerns.

Staff arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. They did this through direct referral to mental health support colleagues in the local community.

Hospice services for adults

Staff shared key information to keep patients safe when handing over their care to others. Staff regularly reviewed and discussed information and handed this over to relevant staff caring for patients. Multidisciplinary meetings were held several times a week, ensuring good communication of individual care needs and risks.

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 staff a full induction.

The service had enough nursing and support staff to keep patients safe. The nursing establishment was based on service demand and patient need.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. Service leads had reviewed the nursing establishment against Royal College of Nursing workforce standards and their own workforce planning review.

The managers could adjust staffing levels daily according to the needs of patients. Staff were flexible and worked across service departments when necessary to adjust staffing levels based on patient dependency. We viewed staffing monitoring records between October and December 2022, these were used to indicate if staffing met planned levels or not. Managers monitored staffing using a traffic light system. Most services were rated green, meaning staffing was over 90% fill rate. The family support and bereavement service in November and December 2022 was below 70% fill rate (red) and the rapid response day service was between 70% and 90% staffed in December 2022 (amber). This had been due to staff absence and had improved by January 2023. Service leads told us that staff in other departments were able to cross cover where appropriate, for example, from the day hospice to the rapid response service.

The number of nurses and healthcare assistants matched the planned numbers.

The service had low vacancy rates. At the time of the inspection there was one 0.2 whole time equivalent vacancy within the lymphoedema service.

The service had low staff turnover rates. In 2022 the rate was 3%.

Managers limited their use of bank staff and used staff familiar with the service. They did not use agency staff. In 2022 they had used 23.5 hours of registered bank nurses and 666 hours of bank care support staff.

Managers made sure all bank and agency staff had a full induction and understood the service.

The service did not employ medical staff. Medical support was accessed through patient's GPs and specialist palliative care services within the local community.

Records

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.

Hospice services for adults

Patient notes were comprehensive and all staff could access them easily. The hospice used an electronic patient record system that was aligned with other services in the community. This enabled the multidisciplinary team to share information and work collaboratively. We reviewed 6 care records during the inspection and found that these were well written with assessments, care plans and delivery clearly recorded.

When patients transferred to a new team there were no delays in staff accessing their records. Notes were written contemporaneously, meaning they were up to date and accessible to staff across the different teams.

Records were stored securely. Computers were password protected and confidentiality of care records was maintained.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. There were no non-medical prescribers working within the hospice at home, rapid response or wellbeing services. Nursing staff within these services liaised closely with GPs and local specialist palliative care teams to ensure medicines were prescribed and available. Non-medical prescribers were working in the lymphoedema clinic. They worked within their prescribing competency and received supervision for non-medical prescribing through a neighbouring hospice that supported the nursing staff. At the time of our inspection, the hospice had issues obtaining prescribing stationery, therefore, required prescriptions were issued through the patient's GP.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Nursing staff working in the rapid response service liaised regularly with GPs and community specialist palliative care consultants and prescribers to ensure that medicines were prescribed and administered when they were needed. We observed nurses discussing medicines administration with patients and family members in relation to managing symptoms experienced at the end of life.

Staff completed medicines records accurately and kept them up-to-date. This included records in patient's homes. Within the wellbeing service, nurses did not administer medicines. They assessed all patients who may require medicines while attending the service, to identify their competency to self-administer. They followed an agreed assessment process. Where patients were unable to independently administer their own medicines, they were supported to do this by staff.

Medicines were stored in patient homes and not in the hospice. Hospice at home staff did not administer medicines in patient's homes. This was generally carried out by the patient or those close to them. However, in the event of issues with this, hospice at home staff could contact the rapid response team for support.

Staff learned from medicines safety alerts and incidents to improve practice. There was a record maintained of alerts received into the service, including any required action taken by staff.

Incidents

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

Hospice services for adults

Staff knew what incidents to report and how to report them. They were able to give examples of incidents that were reflected in the incident log maintained by the service.

Staff raised concerns and reported incidents and near misses in line with the service's incident reporting policy. There had been 6 clinical incidents since April 2022. These included issues with the service pool car, a medication error and information governance issues. There had been no serious incidents in the last 12 months.

Staff understood the duty of candour regulations, which defined provider responsibilities in relation to their responsibilities to people when things went wrong with care and treatment. They were open and transparent and gave patients and families a full explanation when things went wrong. For example, when a medication error occurred where a medicine was administered through the wrong route, an apology was given to the patient's family and an explanation given. Staff shared information about the error with other professionals involved in the patient's care and sought advice as needed. Individual learning and reflections were shared to understand what led to the error and identify learning as a result.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. Examples of changes included a decision within the lymphoedema clinic to send GP correspondence by email rather than through the post due to risks in relation to potential data breaches.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We saw evidence of this in relation to potential data breaches and a medication error that occurred in a patient's home.

Safety alerts were received and cascaded to relevant staff. A log was maintained of relevant alerts and any actions taken.

Is the service effective?

Good 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance however, not all policies had up to date references to national guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Assessment, treatment and care policies and procedures were in place, providing a framework for all services that referenced guidance from the National Institute for Health and Care Excellence (NICE) and clinical guidelines from the relevant royal colleges, associations and the NHS frameworks, where applicable to the hospice setting. However, specific guidelines and knowledge summaries were not always up to date within the policies, for example the consent policy had an expired link to the NICE quality standard [QS13] End of Life Care for Adults which had been updated in September 2021. This meant that staff could be following the incorrect guidance which may impact on patient care. However, staff we spoke with demonstrated an understanding of current guidance around end of life care.

Hospice services for adults

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff had a good understanding of the act and described how they would take action to support patient's rights.

At handover and multidisciplinary team meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff focused on the delivery of holistic care and placed equal importance on the psychological and emotional needs of patients and those close to them.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. They assessed patient's needs and worked collaboratively with other services in the community to ensure those needs were met. Staff supported patients to eat and drink as part of their plan of care. Patients attending the 12 week therapeutic wellbeing service were provided with food and refreshments throughout the day. Refreshments were available at the hospice drop-in service.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Nutritional care planning for patients at the end of life was based on their likes and dislikes.

Specialist support from staff, such as dietitians and speech and language therapists, were available for patients who needed it.

Oral care was provided to patients as required and staff worked closely with family members to ensure there was a focus on patient comfort in the last days of life.

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. This included the use of a facial expression tool to support pain assessments for those unable to articulate their pain level, as well as a sliding scale tool for patients who were unable to verbalise their pain. Staff assessed levels of pain, as well as other symptoms as part of their admission assessment processes and we observed staff assessing pain as part of ongoing care.

Patients received pain relief soon after requesting it and staff administered and recorded pain relief accurately. Staff working in the rapid response service administered pain relief when this was required for patients in the community. They worked with colleagues within the multidisciplinary team to monitor and evaluate how well patient's symptoms were managed and worked collaboratively to coordinate changes in palliative care treatment when this was required.

Patient outcomes

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

Hospice services for adults

Patient outcomes were reviewed on an individual basis as part of their ongoing evaluation of care. This included an evaluation of both the patient receiving care and those close to them in relation to respite and bereavement support.

The use of three of the Outcome Assessment and Complexity measures were well-established in all areas of the service. These are recognised measures used to measure the changes in health status of patients receiving palliative care. These included the Australian Karnofsky Performance Score providing a clinical picture of a patient's health, phase of illness and activities of daily living. The Integrated Palliative Outcome Scale was used to measure the physical, psychosocial, social and spiritual impact of illness, including self-reported patient outcomes. The hospice monitored the proportion of patients at each phase of illness within their quality metrics dashboard. The hospice also used the nationally recognised Carer Support Needs Assessment Tool for end-of-life patients' carer support.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There were assurance audits in place including those relating to record keeping and an evaluation of patient and family feedback. Service leads used outcomes of audits to improve, for example, they had implemented an electronic record system and used information from records audits to inform the development of this. The service had not participated in national audits.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The wellbeing day service was run by registered nurses with experience working in palliative care. Hospice at home was primarily provided by band 3 senior support workers, with band 2 support workers in development roles and nurses providing support for patient assessments. The rapid response team was led by registered nurses working alongside a registered nurse from the local NHS trust community services.

Managers gave all new staff a full induction tailored to their role before they started work. Inductions included working shadow shifts with more experienced staff. Staff told us they were given time to develop into their roles and that support was available to them.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data showed that 91% of clinical staff had received an appraisal in the last year.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. This included quarterly one to one meetings with line managers, staff meetings and external supervision for staff working in the family support service. Managers had been trained to provide resilience based clinical supervision which was designed to enhance well-being and resilience for staff, in order to improve patient care. Staff were positive about their experience of clinical supervision.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. A learning and development plan for clinical services was in operation, providing a framework for



Hospice services for adults

required training for clinical staff. Examples of training provided included communication skills, managing conditions such as breathlessness and diabetes, advanced decisions and health assessment courses. Health care assistants were supported to complete the care certificate and registered nurses were supported to complete the European Certificate in Essential Palliative Care. In addition, staff were supported to attend relevant conferences and care shows.

Managers made sure staff received any specialist training for their role. This included training and competency assessment in relation to administration of medicines using syringe drivers.

Managers identified poor staff performance promptly and supported staff to improve.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteer roles included volunteers working within the family support team and the wellbeing service, facilitating support sessions for patients and those close to them. This included a one to one listening service and support for the 'grief café'.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary (MDT) meetings to discuss patients and improve their care. This included a daily meeting with representatives from community and hospital services, neighbouring hospices and specialist palliative care nurses. The focus of this meeting was to review patient capacity and access MDT support. In addition, a weekly MDT was held with the community specialist palliative care team and another with the hospital specialist palliative care team.

Staff worked across health care disciplines and with other agencies when required to care for patients. This included collaborative working with the local NHS trust community services to deliver the rapid response service, where a nurse from each service worked together across a 12 hour shift to deliver rapid response palliative and symptom control support to patients at the end of life in the community.

Staff referred patients for mental health assessments when they showed signs of mental ill health.

Seven-day services

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

The rapid response service was available 24 hours a day, 7 days a week. The hospice at home service operated 7 days a week between 8.30am and 4.30pm. In addition, a hospice at home overnight service was available between 10pm and 7am.

Health promotion

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

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. The work of the day and wellbeing services aimed to promote independence, maintain function and manage complex clinical problems, to help patients live well for as long as possible. Staff helped patients to address problems with symptom management and the physical, psychological and emotional issues associated with a life limiting illness,

Hospice services for adults

as well as provide support and guidance with financial or social concerns and spiritual care. The support was either offered through a virtual programme delivered by video calls or in face to face groups. The day service was provided through a structured 12 week therapeutic programme that included symptom management and rehabilitative palliative care. Assessments included identifying health and practical issues and providing advice to live well.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients were unable to be involved in decisions about their care, staff discussed care and treatment with those close to them. This included discussions in relation to 'do not attempt cardiopulmonary resuscitation decisions' (DNACPR). DNACPR records were held in patients' homes where all staff involved in their care had access to them, including records of wishes and preferences about treatment.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. They recorded discussions about care and treatment and we observed staff speaking to patients in a way that helped them understand their options. Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records. This included a discussion about consent where staff informed patients of their right to withdraw consent when they wished. In addition, consent was recorded in relation to sharing information with a patient's GP or hospital team.

Clinical staff received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. This was a module that had recently been added to the mandatory training programme. At the time of the inspection, 12 out of 34 eligible staff had completed the training. There was a target for this training to be completed by the end of March 2023.

Managers monitored the use of Deprivation of Liberty Safeguards (DoLS) and made sure staff knew how to complete them. This was included in the hospice's clinical services quality dashboard. Data from October to December 2022 showed there had been no DoLS raised.

Staff could describe and knew how to access policy and get accurate advice on MCA and DoLS. They told us that issues around mental capacity were regularly discussed at multidisciplinary team meetings.

Is the service caring?

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

Compassionate care

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

Hospice services for adults

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff interacting with patients and those close to them in their homes and in the wellbeing service. We saw that staff consistently treated people with compassion and care and built caring and trusting relationships with patients and those close to them.

Patients said staff treated them well and with kindness. Feedback was consistently positive. Patients told us staff were kind and caring and were available to listen to their concerns.

Survey feedback was consistently positive. Both hospice at home and lymphoedema service 'I want great care' feedback showed that 96% of patients had a positive experience of the service. Feedback from patients and those close to them who accessed the rapid response service showed that 100% of them had a positive experience of the service. The hospice at home service scored 4.96 out of 5 in relation to being treated with dignity and respect. All patients scored the service with 5 out of 5 for the caring approach of staff and having trust in them.

Staff followed policy to keep patient care and treatment confidential. They held discreet conversations about patient care and were mindful of confidentiality. Patient records were security protected and only accessible to staff involved in the patient's care.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. They recognised the totality of people's needs and demonstrated compassion when discussing the care of patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Care and support were planned and delivered on an individual basis. We saw examples of staff adjusting their approach to meet these needs. This included increasing support from 1 to 2 carers for a patient being supported by the hospice at home team. This was to enable the person's spouse to receive respite support when caring for the person at home.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff interacting with patients and those close to them in a way that enabled them to access emotional support and advice.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. We observed staff having difficult conversations with patients and those close to them and found them to be skilled in this area. Clinical staff had received training in communication skills which included advanced communication.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The family support service offered emotional support to people approaching the end of life and those close to them. They also provided bereavement support after death. Staff demonstrated awareness of emotional and social support needs and the service reviewed and developed family support services to adapt to changing needs. They provided structured 1 to 1 and group support. This included a bereavement café and a psycho educational group. Support services were delivered face to face and through video and telephone calls. Feedback about the service was positive with patients describing it as 'fantastic', a 'pipeline' and staff as 'listening' and 'not judging'.

Hospice services for adults

The service worked closely with the spiritual team located at the NHS trust where the hospice was situated. This enabled them to access support for patients and families from spiritual support workers and ministers across a range of faiths and spiritual beliefs.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. They took time to explain what they were doing and answer questions about treatment and care.

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. They were encouraged to complete 'I want great care' feedback where they were asked to rate their experience of the service, as well as speaking to staff about their experiences.

Staff supported patients to make advance decisions about their care (where decisions were made in advance of a deterioration in health to ensure that care decisions were based on the individual's wishes). Nurses had been trained to support patients to develop their advance care plans and this was a key focus within the wellbeing service.

Staff supported patients to make informed decisions about their care. They were focused on providing patients and those close to them with information to support informed decision making.

Patients gave positive feedback about the service. Comments included 'I love coming here', 'I can laugh with the staff' and 'it has had a big impact'. 'Thank you' cards included comments such as 'I will never be able to repay you for the wonderful care.' 'I want great care' feedback comments included 'the care and support provided was absolutely amazing.' 'So caring and treated mum with the utmost dignity' and, 'I cannot imagine what we would have done if this service had not been available. It is a value to the community and to families like us.'

The hospice used the Carer Support Needs Assessment Tool Intervention to identify what mattered to carers. This was used within the hospice at home services, where carers were given an 'about you' booklet at the first meeting and encouraged to consider their needs and complete the tool. This enabled staff to recognise the carer's perspective and support them in a way that was based on their priorities. The hospice was recognised by the End of Life Care Partners Think Tank in a Health and Care Act 2022 support document for integrated care boards, for their work supporting more than 1,000 carers over a 4 year period.

Is the service responsive?

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

Hospice services for adults

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population. They worked closely with the wider health economy. This included contributing to the Coventry and Warwickshire Collaborative End of Life Care (EOLC) Committee, the Warwickshire North Palliative Care Network, the local NHS hospitals Strategic and Operational End of Life Committee and the Care and Support towards the end of life (CASTLE) expert advisory group – Coventry and Warwickshire.

Due to the Covid-19 pandemic, day services had been reviewed in order to ensure ongoing accessibility. This involved moving some services to a virtual model. This involved staff supporting patients to set up video systems so they could attend ongoing one to one and group activities.

Other examples of services provided during the pandemic included volunteers dropping off afternoon tea to patient's homes so they could attend a virtual group tea. More recently, ongoing review of the day service led to the development of two models of care. One was a therapeutic rehabilitative palliative care model where structured support was offered to a group of patients who attended the day service on a weekly basis. The structured support involved support around symptom control, advance care planning and emotional, social and spiritual support. In addition, a weekly day service drop in was provided using a social model of care.

In 2019 the hospice worked collaboratively with a local NHS provider to expand the rapid response service from an overnight to a 24 hour service. This expanded on the existing rapid response model where a hospice care support worker worked alongside an NHS nurse to provide rapid response palliative care in the community. During the day, the service included a hospice nurse working alongside an NHS nurse to respond to urgent palliative care needs within the community. This included support for managing symptoms and providing catheter care.

The service had systems to help care for patients in need of additional support or specialist intervention. Service leads worked collaboratively to explore the needs of the local population. Examples of initiatives included working with a children's community service who carried out 'poverty proofing' activities as part of the wider Tackling Social Inequalities in Warwickshire Strategy 2021-30. The aim of this was to better understand the experience of families and individuals living in poverty and why they did or did not engage with the palliative care services.

A further initiative involved working with a telehealth provider to remotely monitor patients living at home with palliative care needs. This service had been provided to 7 patients in the community as part of a pilot and involved them completing health and symptom assessments using remote devices. The information submitted was evaluated by hospice nursing staff and appropriate action taken. For example, a patient was treated for an infection sooner than they might otherwise have been because of the remote monitoring. Evaluation of the pilot included 5 out of the 7 patients self-reporting that they had been less reliant on their GP services as a result of the service and patients and family members felt more confident in the care received.

Facilities and premises were appropriate for the services being delivered. The day service was accessible to patients and visitors. This included single level access and there was equipment available, such as hoists to transfer patients with limited mobility. Clinical rooms were used to provide the lymphoedema clinic and on-site complimentary therapies.

Managers ensured that patients who did not attend appointments were contacted. This included monitoring of 'did not attend' rates and engaging with patients to ensure the service they received were suitable to their needs.

Hospice services for adults

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.

Staff made sure patients living with mental health problems, learning disabilities and dementia received the necessary care to meet all their needs. They adopted an individualised approach to care and worked collaboratively with other services. Service leads understood the training needs of staff to ensure the service was inclusive. This included plans to complete training relating to mental health, a learning disability and dementia.

Staff supported patients living with dementia and a learning disability by using 'This is me' documents and patient passports.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. They could access telephone and face to face interpreters when needed.

The service had information leaflets available and they were able to provide information in languages and formats to meet the needs of patients in the local community on an individual basis as required.

Managers made sure staff and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Individual needs and preferences were identified as part of the hospice assessment processes and staff worked with patients and those close to them to ensure those needs were met.

Staff supported patients in the community and those accessing day services to develop advanced care plans. This ensured a personalised approach to planning care that was centred around individual needs, wishes and preferences. Advanced care planning is a person-centred discussion between an individual and their care provider about their preferences and priorities for their future care. This included speaking to patients about their preferred place of care at the end of life.

Access and flow

Patients could access the hospice service when they needed it.

Managers made sure patients could access services when needed and received treatment and care as soon as possible. Service leads monitored referrals to the service, including referral to visit times for the rapid response service. In 2021/22 there had been 2,153 overnight visits from the service and 1,985 day visits. We saw that 99% of overnight visit requests were responded to within 2 hours of the call, 88% of which were seen within 30 minutes. We found that 96% of day-time calls were responded to within 2 hours, 62% of which were seen within 30 minutes. Timeframes were appropriate and met the service's targets.

Managers worked to ensure that patients referred received the care needed. The hospice at home service worked closely with the local NHS trust to support rapid discharge from hospital for patients identified as being in the last two weeks of life. This included supporting 30% more patients when compared to 2019/20.

Hospice services for adults

Service leads monitored the preferred place of death of patients who died while being supported by the service. Data showed that in 2021/22 92% of patients supported by the service achieved their preferred place of death, either at home or in a care home. Monthly data between October and December 2022 showed that between 95% and 100% of patients achieved their preferred place of death.

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.

Patients, relatives and carers knew how to complain or raise concerns. Information on how to do this was shared when patients first accessed the service.

Staff understood the policy on complaints and knew how to handle them. They understood that it was hospice policy to try and resolve complaints and concerns as quickly as possible and staff were encouraged to liaise with individuals expressing concerns to ensure this happened when appropriate. Where complaints were unable to be resolved immediately, a complaint form was completed and passed to the chief executive to follow up within the agreed timelines of the policy.

Managers investigated complaints to identify themes. There were minimal complaints relating to the services and no themes had been identified. Records showed that complaints relating to services were investigated and viewed alongside other forms of feedback to review and improve services.

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. For example, changes and developments to the wellbeing service incorporated patient feedback into evaluation processes.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The chief executive officer and director of clinical services were the leads for the service. In addition, there were associate directors of clinical services and of people development and education.

Service leads understood the priorities and issues facing the service and had developed plans to address these. They had succession plans in place, including developmental roles for transitioning into senior positions as part of retirement plans of senior staff. Staff told us the leads were visible and approachable and that they provided support as needed.

Hospice services for adults

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 hospice had a 2021 – 2024 strategic plan that had been developed with the involvement of the executive team, board of trustees, staff and external stakeholders. Strategic objectives included work towards developing a single point of access for hospice services across Coventry and Warwickshire, working collaboratively with providers and commissioners within the wider health economy to embed this. Other objectives included the introduction of a new model for end of life care developed by another hospice, providing a framework for nursing competencies and metrics for evaluating the impact of care.

We saw that the strategy was regularly reviewed. Achievements included embedding the role of a new director of clinical services, which we saw had been managed through a developmental process.

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.

Staff were consistently positive in their view of working within the hospice and described experiences that were rewarding and supportive. There was a clear patient centred focus on care and staff told us of ways they adapted care to meet the needs of individual patients.

The service had a focus on equality and diversity in daily work, including building a workforce to reflect the communities served. They had plans in place to further develop both volunteer and staff roles. We saw that staff had access to training that supported the development of their careers, including completing the European Certificate in Essential Palliative Care for band 6 nursing staff.

The service had processes for patients, their families and staff to raise concerns. This included the use of feedback surveys, complaints and whistleblowing processes. There were freedom to speak up guardians identified within the staff team and at board level to support staff to raise concerns safely. The associate director of clinical services led on resilience work to support the staff team. Specific activities included the development of a wellbeing newsletter where staff and volunteers were given tips on supporting their wellbeing. A mental health workshop was planned for February 2023, giving staff the space to discuss mental health and wellbeing.

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.

There were effective governance structures, processes and systems of accountability and a clear governance framework to support the delivery of the hospice strategy. The hospice leadership team were accountable to the board of trustees. Service leads reported to the board of trustees through board papers submitted, including a regular clinical services report. A sub-committee structure was in place, with each sub-committee chaired by a trustee. This included clinical, people, business and marketing and income sub committees.

Hospice services for adults

We saw that issues around quality, risk and compliance were discussed at sub-committee meetings. Clinical sub-committee meeting minutes we reviewed showed that issues such as clinical audit, service updates, data and quality metrics, incidents and complaints, workforce updates and training compliance were discussed. Hospice policies were ratified by the relevant sub-committee. Board of trustee meetings included a review of governance, strategic development, financial controls and sub-committee papers.

Weekly leadership hub meetings were held where strategic, operational and development issues were discussed, and full hospice staff meetings were held periodically. Team brief weekly meetings were chaired by the head of clinical operations to connect with clinical operational staff. Additional weekly clinical hub and monthly service team leads meetings were held. Meetings provided the opportunity for staff to feedback and make suggestions and information from this would be incorporated into the care services reports that went to the relevant committee and board of trustees. All hospice meetings were held quarterly to ensure that all staff and volunteers were aware of the performance of the hospice and future plans. A variety of information bulletins were prepared by various staff such as a 'green' environmental newsletter and a wellbeing newsletter. These were shared with staff on a regular basis.

The hospice had a range of policies to help govern the service. We reviewed policies including safeguarding, complaints, consent, equality and diversity, medicines management and treatment and care.

Management of risk, issues and performance

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.

The service had organisational and clinical risk registers where risks were identified, including in relation to areas such as service provision, staffing, infection control, health and safety, standards of care, information governance and finance. Control measures and relevant gaps were identified as part of the risk management process. We saw that risks were reviewed as part of committee and board meetings and the register updated with progress measures. Staff told us that the main risks to the service related to staffing and we saw that this was reflected within the risk registers. Action to mitigate risks included the use of development roles and different routes for advertising vacant posts.

Risk assessments were carried out in relation to areas such as premises, patient visits and lone working. We saw the service had comprehensive lone working processes including the use of lone working devices.

Performance was monitored through a quality dashboard of collated information relating to incidents, activity levels, patient feedback, staffing and other risks.

The hospice had a clear focus on business continuity. This involved anticipating events that may impact the service and planning ways to mitigate the potential risks.

Information Management

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.

Hospice services for adults

The service collected activity data and reviewed it as part of their governance and development processes. The information collected was analysed and used to populate reports to ensure adequate oversight, decision making and improvements. Service leads were aware of the requirement to submit notifications to external organisations including the Care Quality Commission.

Staff had access to up to date and comprehensive information about patient's treatment and care. They used an electronic patient record system that was also used by other services across the region. They had information governance processes in place and staff had received training in how to maintain the security of information. They informed patients of their rights in relation to the information stored and requested consent for sharing of information with other services involved in the patient's treatment and care.

We reviewed 5 patient records during our inspection and found these were appropriately maintained. There were clear and standardised information governance processes that ensured the security of patient information. Computers and electronic devices were encrypted and password protected.

Engagement

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

The service leads recognised that they needed to engage with stakeholders in order to develop their services. We saw examples of engagement with other providers including GPs, community nurses, specialist nurses and other organisations involved in end of life care. Senior leaders were involved strategically in regional and local end of life care boards and operationally in relation to sustainability and quality of end of life care services locally. Senior staff had additional roles within organisations including the local Healthwatch and the National Association for Hospice at Home and the regional Executive Clinical Leads in Hospice and Palliative Care.

Senior staff collaborated with partner organisations to improve services for patients. This included coproducing services and benchmarking to identify gaps in service provision with a view to developing services that meet the needs of the local communities.

We saw examples of the service engaging with staff about working in the service. This included regular surveys where feedback was collated. We saw an action plan from the most recent survey in November 2022 which included improving 'speak up' processes for clinical staff, the development of a 'people charter' and training for senior staff on providing feedback.

Senior staff had developed an 'I matter' approach to staff engagement. This included regular meetings and the implementation of freedom to speak up champions across the staff team. Staff and volunteer meetings and forums were held regularly.

Learning, continuous improvement and innovation

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

There were processes for continuous improvement and shared learning. There was a programme of clinical audits in place to provide assurance and action was taken to improve.

Hospice services for adults

Incidents were reviewed and learning shared to make improvements.

The service had clear plans to develop the service to ensure it met the needs of patients and the local community. There were examples of the service looking at ways to improve the service and engage with other services and professionals to support this process.

Senior staff encouraged and participated in research and they maintained a research register. Examples included participation in the Optimum Hospice at Home Services for End of Life Care (OPEL) study.